

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155678		X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2011	
NAME OF PROVIDER OR SUPPLIER  WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN46901			
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: February 15, 16, 17, 18 and 21, 2011</p> <p>Facility number: 002667 Provider number: 155678 AIM number: 200300090</p> <p>Survey team: Toni Maley, BSW, TC Tammy Alley, RN Donna Smith, RN</p> <p>Census bed type:</p>			F0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	SNF: 38 SNF/NF: 44 Residential: 35 Total: 117  Census payor type: Medicare: 34 Medicaid: 26 Other: 57 Total: 117  Sample: 17 Supplemental sample: 3 Residential sample: 6  These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review 3/01/11 by Suzanne Williams, RN						

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F0223 SS=A	<p>Based on record review and interview, the facility failed to prevent verbal abuse from occurring for 1 of 7 residents reviewed for verbal abuse in a sample of 17. (Resident # 11)</p> <p>Findings include:</p> <p>1. An undated policy titled "Abuse and Neglect Procedural Guidelines" was provided by the Administrator on 2/15/11 at 12:55 p.m., and deemed as current. The policy indicated: "Purpose:...has developed and implement processed, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures...Verbal Abuse-may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. i. Staff to resident-any episode...."</p> <p>2. During review of reportable occurrences on 2/16/11 at 10 a.m., the following was indicated: On 12/29/10 at</p>			F0223	<p>1. Resident #11 was interviewed by Social Services on 12/30/10 and determined through resident interview that there was no negative interactions with staff members and the resident's verbal exchange with the nurse left no negative impact.2. Other residents on the unit were interviewed and assessed by Social Services to determine if they had been subject to any type of abuse or if they had experienced any negative experiences of any type with campus staff. It was determined that no residents felt abused.3. Staff will be inserviced on the company abuse and neglect policy.4. All allegations of abuse will be investigated and any trends identified will be reviewed monthly as part of the ongoing QA process.5. 3/23/11</p>		03/23/2011

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	<p>9:15 p.m., a family member of another resident alleged that he had heard a nurse become verbally abusive with Resident # 11. The family member would not give detailed information. He reported the event to the Director of Nursing who initiated an investigation and immediate suspension of the alleged LPN # 28.</p> <p>A 12/29/10 written statement from LPN # 28, she indicated Resident # 11 requested medication for himself and his room-mate. Resident # 11 was cursing and threatening toward the nurse. In the statement, she indicated she had asked him to stop yelling to prevent upsetting the other residents. She indicated she stated to the resident "There is no need to act like a 2 year old. Your yelling and threatening doesn't help." The LPN indicated she apologized.</p> <p>On 12/30/10, LPN # 28 was given a written reprimand for her behavior.</p> <p>On 12/30/10 the Director of Resident Services met with Resident # 11. At that time he indicated he had no negative interactions with staff members.</p> <p>On 2/21/11 at 2 p.m., the administrator indicated he was immediately informed of the event and the investigation was</p>						

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F0250 SS=D	<p>completed.</p> <p>3.1-27(b)</p> <p>Based on record review and interview, the facility failed to ensure a behavior was evaluated and assessed as indicated in the nurse's notes to identify possible interventions to promote a resident's psychosocial well-being for 1 of 4 residents reviewed for behaviors in a sample of 17. (Resident #73)</p> <p>Findings include:</p> <p>1. Resident #73's record was reviewed on 2/15/11 at 3:50 p.m. The resident's diagnoses included, but were not limited to, chronic leukocytosis, hypertension, history of spinal stenosis with weakness to both legs, 2/02/11 fifth metatarsal fracture and right distal fibula fracture, and double knee replacement. The physician's order indicated weight bearing as tolerated and physical therapy.</p> <p>The nurse's notes, dated 2/06/11 at 1:30 p.m., indicated as the RN passed by the resident's room with no call light on, the resident was heard to say she could not hold it anymore. Upon checking on the resident, the RN summoned a CNA to</p>			F0250	<p>1. Resident #73 was assessed by Social Services on 2/18/11. Interventions related to resident's feelings were addressed at that time.2. Current residents of the campus will be reviewed in the "Clinically At Risk" (CAR) meeting for mental health needs. Identified concerns will be assessed and addressed with Social Services for appropriate interventions.3. The staff of the campus will be inserviced on identification of behaviors triggering the need for Social Service assessment and follow up by 3/23/11. The 24 hour report will be reviewed during clinical meeting for any behaviors that might require follow up and Social Service notified in the morning Stand-Up meeting. Social Service will attend CAR for the behavior review weekly.4. The results from the Clinical Stand Up will be brought to QA with any trends identified. These results will be reviewed monthly for three months and then quarterly.5. 3/23/11</p>		03/23/2011

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	<p>assist the resident, but before she was able to assist the resident, the resident had been incontinent of urine in her pants. The resident was crying and stating she was not coming out of her room. Social service was to be notified to talk to the resident.</p> <p>No further information was indicated concerning the notification of Social Services prior to 2/18/11.</p> <p>The Social Service progress notes, dated 2/18/11 at 8:30 a.m., indicated Social Service was notified "last evening (02/17/2011)" concerning the resident's continence and call light/staff responsive time upon admission. During this visit the resident was asked about her mood and began crying. The resident continued to express feelings of helplessness and worthless not being able to take care of herself. Steps were taken to address interventions for the resident's feelings at this time. Also, a "Geriatric Depression Scale," dated 2/18/11, was completed with a total score of 8 with a score above 5 suggesting depression.</p> <p>On 2/15/11 at 10:30 a.m. during the initial tour, RN #45 indicated Resident #73 was transferred by the mechanical lift, wore a right walking boot, but she did not</p>						

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	ambulate at this time.  2. The "CLINICALLY AT RISK (CAR) PROGRAM GUIDELINES FOR BEHAVIOR DISCUSSION AND INTERVENTIONS" policy was provided by the Nursing Consultant on 2/17/11 at 12:00 p.m. This current policy indicated the following:  "The Social Service Director should be in attendance for the discussion of residents exhibiting behaviors.  Criteria for residents who will be followed by the CAR team: * Residents with behavior issues that impact their care of the care of others. Resident is to be discussed in CAR until behavior concern is manageable....."  3.1-34(a)						

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F0278 SS=D	<p>Based on record review and interview, the facility failed to accurately assess weight loss on a significant change Minimum Data Set Assessment (MDS) for 1 of 9 residents reviewed for weight loss in a sample of 17. (Resident # 11)</p> <p>Findings include:</p> <p>1. The record for Resident # 11 was reviewed on 2/15/11 at 1:25 p.m.</p> <p>Current diagnoses included, but were not limited to, pernicious anemia, Diabetes Mellitus, renal failure, and dementia.</p> <p>The resident was readmitted to the facility on 11/11/10. A "Nutritional Assessment" dated 11/15/10 indicated the resident had an actual weight of 216.4 pounds.</p> <p>A "Vital Signs and Weight Record" indicated the following weights:</p> <p>11/17/10: 206.1 12/2/10: 207.4 12/9/10: 208.4 12/16/10: 195.2 Physician and family notified 12/20/10: 190.2 1/3/11: 186 Physician and family notified 1/11/11: 178.6 Physician and family notified</p>		F0278	<p>1. The MDS has been corrected on resident #11.2. The MDS Coordinator will review current resident's weight history to determine if any other residents trigger a significant change for weight loss. Any resident that triggers a significant change will have a correction or significant change completed.3. The MDS Coordinator will be inserviced by clinical support on significant change MDS for weight loss. Weight changes will be reviewed in the CAR meeting and any significant changes will be communicated to the MDS coordinator by the DHS/designee.4. Weight loss that triggers will be reviewed by the DHS/designee weekly at the CAR meeting. Significant change MDS's will be reviewed by the DHS until 100% compliance is achieved then monthly as part of the ongoing QA process.5. 3/23/11</p>		03/23/2011	

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	2/9/11: 171.8 Physician and family notified  A 1/24/11 nursing assessment indicated the resident weighed 178.6 pounds.  A 1/28/11 significant change Minimum Data Set Assessment (MDS) failed to indicate the resident had had weight loss. The weight recorded on the MDS was 178 pounds which was 38 pound less than the prior MDS assessment of 11/21/10. This was a 17 % weight loss in less than 3 months. (216 pounds -178=38/216=17%)  During an interview with the MDS coordinator # 29, she indicated the weight loss had been missed on the MDS and weight loss did not trigger as a problem.  3.1-31(d)						

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F0279 SS=D	<p>Based on record review and interview, the facility failed to ensure weight loss was identified as a problem on a plan of care for 1 of 9 residents reviewed for weight loss in a sample of 17. (Resident # 11)</p> <p>Findings include:</p> <p>1. The record for Resident # 11 was reviewed on 2/15/11 at 1:25 p.m.</p> <p>Current diagnoses included, but were not limited to, pernicious anemia, Diabetes Mellitus, renal failure, and dementia.</p> <p>The resident was readmitted to the facility on 11/11/10. A "Nutritional Assessment" dated 11/15/10 indicated the resident had an actual weight of 216.4 pounds. The assessment indicated the resident consumed 88.7 % of meals and had an albumin of 2.9 on 11/1/10.</p> <p>A "Vital Signs and Weight Record" indicated the following weights:          11/17/10: 206.1          12/2/10: 207.4          12/9/10: 208.4          12/16/10: 195.2 Physician and family notified          12/20/10: 190.2          1/3/11: 186 Physician and family notified</p>		F0279	<p>1. Resident #11 care plan was updated at the time of survey with interventions to address weight loss.2. Current residents of the campus will have their weights reviewed by clinical support/DHS and their care plans will be updated with interventions to address weight loss.3. Licensed staff will be in serviced on signs and symptoms of weight loss and interventions. The weight histories of the residents will be reviewed at the CAR meeting monthly for all campus residents and weekly for the "at risk" residents as identified by their assessments/consumption records.4. The DHS/designee will review the weights monthly for triggered weight loss as part of the ongoing QA process. The DHS/designee will review the "at risk" residents weekly in the CAR meeting and trend monthly as part of the ongoing QA process.5. 3/23/11</p>		03/23/2011	

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	1/11/11: 178.6 Physician and family notified 2/9/11: 171.8 Physician and family notified  The above form had an identified place for the dietary to be notified. This area of the form was blank.  Physician progress notes dated 12/2/10, 12/6/10, 12/13/10, and 1/24/10 does not mention the resident's weight loss.  CAR (Clinically at Risk) meeting notes dated 12/2/10 indicated the resident weighed 207.4 pounds and consumed 63% of meals. On 12/9/10 with weight was 208.4 with the resident consuming 66 % of meals. On 12/16/10 the weight was recorded as 195.2 pounds with the resident consuming 70 % of meals. On 12/22/10 the weight was recorded at 190.2 pounds, no consumption was recorded. On 12/29/10 the weight was recorded at 192 with no consumption and on 1/5/11 the weight was recorded at 186 pounds. In the area of the form that indicated "Resident continues with weigh instability. See below for updated interventions" did not mention weight loss or any interventions to be implemented. Between 12/2/10 and 1/5/11 the resident lost 21.4 pounds which						

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	<p>was a 10.3 % weight loss. The Certified Dietary Manager was not in attendance at the CAR meeting 12/2/10-12/29/10. On 2/18/11 at 10:30 a.m., during interview, the Certified Dietary Manager # 27 indicated she was on sick leave during between 12/2-29/10. She did sign the CAR note on 1/5/11 as being in attendance. During the above interview, she indicated she did not know who was to communicate to the dietician during her absence. She further indicated, the resident should have been on the list to see the dietician due to his weight loss. On 12/20/10 Juven (protein supplement) was added for wound healing due to open areas on his bottom.</p> <p>A CAR note dated 1/12/11 indicated the resident weighed 178.6 pounds and consumed 50 % if meals, still no interventions are implemented for the weight loss.</p> <p>On 1/15/11 the resident was admitted to the hospital with acute renal failure. A 1/17/11 (name of hospital) progress note indicated the resident had an albumin of 1.9 (low) which suggested poor nutritional status and protein calorie malnutrition with weight loss. The family declined a gastrostomy tube and speech had suggested a special diet. A 12/7/10</p>						

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	<p>laboratory report indicted the resident's albumin was 3.4 which was within normal limit.</p> <p>A 1/16/11 (name of hospital) "Nutritional Assessment Form" indicated the resident had lost 40 pounds in 2 months. The form indicated the resident was placed on sugar free vanilla health shakes with breakfast and dinner, sugar free pudding with breakfast, oatmeal with breakfast and brown sugar portion with breakfast. The form indicated the resident had significant weight loss of 19 % in 2 months which the daughter confirmed, and the resident very likely had protein-calorie malnutrition.</p> <p>The resident was readmitted to the facility on 1/20/11 with a pureed diet with nectar thick liquids. No supplements or other dietary interventions were implemented except Juven. (protein supplement)</p> <p>A 1/24/11 nursing assessment indicated the resident weighed 178.6 pounds.</p> <p>The resident was admitted to hospice care on 1/27/11. On 2/21/11 at 11:10 a.m. during an interview with the hospice RN, she indicated the resident was started on Decadron (steroid) on 2/4/11 for appetite stimulation.</p>						

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	<p>During an interview with Registered Dietician on 2/17/11 at 2:50 p.m., she indicated she was not aware the resident had significant weight loss until January 27, 2011. She indicated she had not seen the resident until this day.</p> <p>A 2/17/11 "Quarterly -Weekly Nutrition Progress Overview" indicated the resident had a 45.4 pound weight loss which was 21 % in 90 days. At this time, she had recommended sugar free Med Pass 60 milliliters three times daily due to significant weight loss.</p> <p>The record lacked a plan of care for weight loss until 2/17/11.</p> <p>3.1-35(a)</p>						

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F0282 SS=E	<p>Based on observations, interviews, and record reviews, the facility failed to ensure the physician's orders were followed related to accuchecks and insulin coverage for 3 of 3 residents (Resident #'s 73, 108, and 11) reviewed for accuchecks/insulin coverage and TED hose for 2 of 2 residents (Resident #51 and #93) reviewed with TED hose in a sample of 17.</p> <p>Findings include:</p> <p>1. Resident #73's record was reviewed on 2/15/11 at 3:50 p.m. The resident's diagnoses included, but were not limited to, diabetic mellitus.</p> <p>The physician order, dated 2/02/11, was Apridria sliding scale was Blood sugar (BS) 80 to 100 = 20 units (u); BS 201 to 150 = 30 u; BS 151 to 200 = 35 u; BS 201 to 250 = 40 u; BS 251 to 300 = 45 u; if BS greater than 300= 50u.</p> <p>The physician's order, dated 2/03/11, was accuchecks before meals with Apridria (Insulin) coverage.</p> <p>The "DIABETIC MONITORING FLOW SHEET" for 2/2011 indicated no information for the "before dinner" accucheck and/or insulin coverage if needed on 2/10/11.</p>		F0282	<p>1. Residents #73, 108, and 11 have had assessments completed and their physician notified with no negative outcomes. The nurses involved in the alleged deficient practice have been coached and counseled on the importance of completing blood glucose as ordered. Residents #93 and 51 have been assessed for the continued use of TED hose and appropriate orders obtained.2. The blood glucose records for current residents will be reviewed for completion of tests as ordered. Any residents with omissions will be assessed and reviewed with their physician. Current residents with orders for TED stockings will be implemented according to physician order. 3. Licensed staff will be inserviced on the importance of completing blood glucose as ordered and the use of TED hose or other stockings as physician orders. Licensed staff will monitor the use of TED hose or other stockings during their rounds as indicated on the CRCA assignment sheet.4. The DHS/designee will monitor the completion of the blood glucose 5 days per week at clinical meeting. The DHS/designee will monitor by direct observation daily the application of stockings as indicated by orders and the CRCA assignment sheet. This will be done until 100% compliance is</p>		03/23/2011	

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	<p>2. Resident #108's record was reviewed on 2/17/11 at 8:20 a.m. The resident's diagnoses included, but were not limited to, diabetic mellitus.</p> <p>The physician order, dated 12/15/10, was to start accuchecks 2 times a day on 12/21/10 and were scheduled for 6:00 a.m. and 4:00 p.m. .</p> <p>The physician order, dated 12/21/10, was a sliding scale with Novolog insulin as follows:</p> <p>Blood sugar (BS) 160 to 200 = 2 units (u); BS 201 to 250 = 3 u; BS 251 to 300 = 4 u; BS 301 to 350 = 5 u; BS 351 to 400 = 6 u; call if BS greater than 401 or less than 60.</p> <p>The "DIABETIC MONITORING FLOW SHEET" indicated no blood sugar result and/or insulin coverage information for the following:</p> <p>12/02 - 4:00 p.m. blood sugar of 272 and the 9:00 p.m. blood sugar of 280; 1/21 - 6:00 a.m. blood sugar of 207 with 4 units of insulin coverage indicated as given (201-250 = 3 units); 2/08 - 4:00 p.m. no information.</p> <p>On 2/17/11 at 2:50 p.m. during an interview with the nursing consultant and administrator, information was requested concerning Resident #73 and Resident #108.</p>				<p>obtained for 4 weeks then twice weekly indefinitely. Results will be reviewed by the QA committee monthly for six months and then at least quarterly.5. 3/23/11</p>		

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	<p>On 2/18/11 at 1:40 p.m. during an interview, the Director of Nursing indicated she had no further information concerning the accuchecks and insulin coverage. She also indicated for clarification the 1/21/10 blood sugar for Resident #108 at 6:00 a.m. was 207.</p> <p>On 12/21/11 at 2:20 p.m. during an interview, the ADON indicated blood sugar results and insulin coverage should be documented on the resident's diabetic flow sheet.</p> <p>3. Resident #51's record was reviewed on 2/17/11 at 9:55 a.m. The resident's diagnoses included, but were not limited to, diabetes, hypertension, and congestive heart failure.</p> <p>The physician order, dated 1/25/11, was knee high TED hose on in am and off at hour of sleep.</p> <p>The physician order, dated 2/11/11, was TED hose on hold until seeping of leg stops.</p> <p>The "SKILLED NURSING ASSESSMENT AND DATA COLLECTION" indicated the following:</p> <p>On 2/11/11 - No edema was indicated.</p>						

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	<p>On 2/12/11 - Generalized lower extremity at 1+ and 2+ pitting edema was indicated.</p> <p>On 2/13/11 - No edema was indicated.</p> <p>On 2/15/11 - Bilateral lower leg extremity 1+ pitting edema was indicated.</p> <p>On 2/16/11 - 1+ and 2+ pitting edema was indicated with no specifics given.</p> <p>On 2/17/11 - Bilateral lower extremity with 1+ pitting edema was indicated.</p> <p>No information was indicated concerning the seeping of liquid from the resident's legs.</p> <p>On 2/15/11 at 1:47 p.m., the resident was observed in bed with no TED hose on and no seepage of her legs observed.</p> <p>On 2/17/11 at 755 a.m., at 8:50 a.m., and at 11:00 a.m., Resident #51 was observed with no TED hose on.</p> <p>On 2/17/11 at 11:00 a.m., the ADON assisted CNA #19 with the Hoyer lift, and the resident was transferred back to her bed from her wheelchair. As the resident was undressed to prepare for her dressing change, the resident's legs were observed dry with no seepage of liquid observed. At this same time during an interview, CNA #19 indicated her legs had not seeped any liquid for "a couple of days" now. She also indicated the left leg had</p>						

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	been the worse, and the fluid had just "poured" from her legs.						

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F0282 SS=E	<p>4. The record for Resident # 11 was reviewed on 2/15/11 at 1:25 p.m.</p> <p>Current diagnoses included, but were not limited to, Diabetes Mellitus.</p> <p>A physician order dated 1/20/11 indicated an order for accuchecks three times daily before meals, with sliding scale insulin as follows: 151-200=2 units, 201-250=3 units, 251-300=4 units.</p> <p>The Medication Administration Record (MAR) for February 2011 lacked accucheck results on 2/2/11 before dinner and 2/14/11 before lunch. On 2/11/11 before dinner the residents accucheck was 260, no insulin is documented as given, 4 units should have been given.</p> <p>Additional information was requested from the Director of Nursing on 2/17/11 at 4 p.m. regarding the above accuchecks and insulin administration.</p> <p>On 2/18/11 at 10 a.m., the Director of Nursing indicated she had no additional information to provide.</p> <p>5. The record for resident # 93 was reviewed on 2/17/11 at 9:30 a.m.</p> <p>Current diagnoses included, but were not</p>			F0282	<p>1. Residents #73, 108, and 11 have had assessments completed and their physician notified with no negative outcomes. The nurses involved in the alleged deficient practice have been coached and counseled on the importance of completing blood glucose as ordered. Residents #93 and 51 have been assessed for the continued use of TED hose and appropriate orders obtained.2. The blood glucose records for current residents will be reviewed for completion of tests as ordered. Any residents with omissions will be assessed and reviewed with their physician. Current residents with orders for TED stockings will be implemented according to physician order. 3. Licensed staff will be inserviced on the importance of completing blood glucose as ordered and the use of TED hose or other stockings as physician orders. Licensed staff will monitor the use of TED hose or other stockings during their rounds as indicated on the CRCA assignment sheet.4. The DHS/designee will monitor the completion of the blood glucose 5 days per week at clinical meeting. The DHS/designee will monitor by direct observation daily the application of stockings as indicated by orders and the CRCA assignment sheet. This will be done until 100% compliance is</p>		03/23/2011

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	<p>limited to, Diabetes Mellitus and hypertension.</p> <p>Current physician orders for February 2011 indicated an order of TED hose to be on Left lower extremity in the morning and off in the p.m.</p> <p>On 2/18/11 at 8 a.m., the resident was in his wheelchair in the hallway. No TED hose was observed to his left lower extremity.</p> <p>On 2/18/11 at 8:20 a.m., during interview, LPN # 26 indicated she was unsure if the family wanted the TED hose on the resident and the TED hose was not on the resident at the present time.</p> <p>3.1-35(g)(2)</p>				<p>obtained for 4 weeks then twice weekly indefinitely. Results will be reviewed by the QA committee monthly for six months and then at least quarterly.5. 3/23/11</p>		

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F0309 SS=D	<p>Based on interview and record review, the facility failed to ensure cognitively impaired residents had on-going bowel monitoring and interventions to prevent and address constipation, for 2 of 6 cognitively impaired residents reviewed for bowel monitoring in a sample in a sample of 17. (Residents #63 and #104)</p> <p>Findings include:</p>			F0309	<p>1. Resident #63 and #104 have been assessed and assessments reviewed with their physicians with no negative outcomes.2. Current residents with the potential for constipation have been assessed and interventions put in place as appropriate.3. The licensed staff will be in serviced on assessment, interventions, and documentation of the assessment and interventions to prevent constipation. The 3 days without BM report will be run and reviewed by the licensed nurse daily and appropriate assessment and interventions completed. The assessment and interventions will then be recorded in the medical record and on the 24 hour report for follow up.4. The DHS/designee will review the 24 hour report and the 3 days with no BM report at least 5 days per week to determine residents are assessed and appropriate interventions implemented to prevent constipation until 100% compliance is obtained. Thereafter, the DHS/designee will review at least 3 times weekly as part of the ongoing QA process.5. 3/23/11</p>		03/23/2011

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	<p>1.) Review of a current, undated, facility policy, titled, "GUIDELINES FOR RESIDENTS WITH CONSTIPATION", which was provided by the Nursing Consultant on 2/21/11 at 1:24 p.m., indicated the following:</p> <p>"Monitor daily bowel movements and record elimination.</p> <p>Nurse aids should report any unusual elimination pattern such as diarrhea, hard stool, blood in stool, etc., to the nurse.</p>						

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	<p>If recorded elimination indicated resident has not had a bowel movement in three days a nursing assessment should be completed that includes a notation regarding bowel sounds, abdominal distention, firmness of abdomen, and tenderness or guarding.</p> <p>Results of the nursing assessment should be communicated to the physician with request for an order of milk of magnesia or other</p>						

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	<p>laxative/interventions as prescribed by the doctor.</p> <p>If facility has standing physician's orders for constipation these orders may be followed."</p> <p>2.) Resident #104's record was reviewed on 2/15/11 at 11:50 a.m.</p> <p>Resident #104's current diagnoses included, but were not limited to, dementia, depression and anorexia.</p> <p>Resident #104 had current 2/11, physician's</p>						

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	<p>orders for the following medications which aid in bowel elimination:</p> <p>a.) Senna-S tablet-give 2 tablets 3 times a day for constipation. This order originated 9/29/10</p> <p>b.) Milk of Magnesia (MOM)-30 cc orally if no BM in last 3 days. This order originated 4/21/10</p> <p>c.) Dulcolax 5 mg-give 2 tablets (10 mg) if no results for MOM after 12 hours. This order originated 4/21/10</p>						

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	<p>d.) disposable enema- administer 1 enema rectally 12 hours after dulcolax, if no results in 4 hours call physician. This order originated 2/19/10.</p> <p>Resident #104 had a current 11/10/10, quarterly, "Minimum Data Set" assessment which indicated the resident was severely cognitively impaired and rarely or never made choices and needed staff assistance for toileting needs.</p>						

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	<p>Resident #104 had a current 2/2/11, care plan problem regarding the potential for constipation. Approaches to this problem included, but were not limited to, "Monitor bowel movements for amount and consistency," "If no BM [bowel movement] in three days MOM [Milk of Magnesia] per order, "If no BM in 12 hours give dulcolax supp [suppository] per order," "If no BM in 12 hours enema per order," and</p>						

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	<p>"If no results notify physician."</p> <p>A review of Resident #104's bowel monitoring record for 12/2010, 1/2011, and 2/1/11 through 2/16/11 indicated Resident #104 had lack of documented bowel movements and/or bowel elimination concerns during the following periods of time:</p> <p>a.) No documented bowel movements from 12/13/10 through and including 12/18/10 (6</p>						

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	<p>days). The clinical record indicated MOM was given 12/13/10 with no results. No other documented medication was administered in accordance with the resident's care plan and orders. Resident #104's record lacked documentation of an assessment of bowel functioning during this period of time.</p> <p>b.) No documented bowel movements from 12/29/10 through and including 1/2/11(5 days). The clinical record</p>						

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	<p>indicated MOM was given 1/1/11(after 4 days without BMs) without results. No other documented medication was administer in accordance with the resident's care plan and orders. Resident #104's record lacked documentation of an assessment of bowel functioning during this period of time.</p> <p>c.) No documented bowel movements from 1/5/11 through and including 1/9/11 (6 days). The record</p>						

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	<p>indicated the resident received dulcolax on 1/6/11 without results. No other documented medication was administer in accordance with the resident's care plan and orders. Resident #104's record lacked documentation of an assessment of bowel functioning during this period of time.</p> <p>d.) No bowel movements documented from 1/11/11 through and including 1/15/11 (5 days). The record indicated MOM was</p>						

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	<p>administered on 1/15/11. During the 5 days prior to 1/15/11 no medication to address constipation was documented as administered or an assessment of bowel functioning during this period of time.</p> <p>e.) No bowel movements documented from 1/22/11 through and including 1/31/11(10 days). The record indicated MOM was administered 1/24/11 without documented results. The record indicated dulcolax was</p>						

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	<p>administered 1/25/11 without documented results. No other documented medication was administer in accordance with the resident's care plan and orders. Resident #104's record lacked documentation of an assessment of bowel functioning during this 10 day period of time.</p> <p>f.) No bowel movement documented from 2/9/11 through and including 2/13/11(5 days). The record indicated MOM was administered on</p>						

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	<p>2/13/11 after 5 days without a documented BM. Prior to the MOM administration on 2/13/11, no other documented medication was administer in accordance with the resident's care plan and orders. Resident #104's record lacked documentation of an assessment of bowel functioning during this period of time.</p> <p>3.) Resident #63's record was reviewed on 2/18/11 at 10:00 a.m.</p>						

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	<p>Resident #63's current diagnoses included, but were not limited to, dementia and depression.</p> <p>Resident #63 had a current 2/11, physician's orders for the following medication to aid in bowel elimination:</p> <p>a.) Milk of Magnesia(MOM)-30 cc orally if no BM in last 3 days. This order originated 10/29/10.</p> <p>c.) Dulcolax 5 mg-give 2 tablets (10 mg) if no results for MOM after 12</p>						

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	<p>hours. This order originated 10/29/10.</p> <p>d.) disposable enema-administer 1 enema rectally 12 hours after dulcolax, if no results in 4 hours call physician. This order originated 10/29/10.</p> <p>Resident #63 had a current, 12/5/10, quarterly "Minimum Data Set" assessment, which indicated the resident was severely cognitively impaired and rarely if ever made decisions and required</p>						

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	<p>staff assistance for toileting needs.</p> <p>A review of Resident #63's bowel monitoring record for 1/2011, and 2/1/11 through 2/16/11 indicated Resident #63 had lack of documented bowel movements and/or bowel elimination concerns during the following periods of time:</p> <p>a.) No documented bowel movements from 1/27/11 through and including 1/30/11(4 days). No documented</p>						

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	<p>medication was administer in accordance with the resident's orders. Resident #63's record lacked documentation of an assessment of bowel functioning during this 4 day period of time.</p> <p>b.) No documented bowel movements from 2/1/11 through and including 2/7/11 (7 days). No documented medication was administer in accordance with the resident's care plan and orders. Resident #63's record</p>						

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	<p>lacked documentation of an assessment of bowel functioning during this 7 day period of time.</p> <p>During a 2/21/11, 10:00 a.m., interview the Director of Nursing indicated the facility did not have any additional information to provided regarding bowel monitoring, bowel elimination and bowel assessing for Residents #104 and #63 during December, January and February.</p> <p>3.1-37(a)</p>						

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F0314 SS=G	<p>Based on observations, record review, and interviews, the facility failed to ensure pressure areas were assessed and preventive measures and treatments were utilized to promote the healing of these pressure areas for 4 of 5 residents reviewed in a sample of 17, with 1 resident's pressure area (Resident #51) deteriorating in a short period of time. (Resident #'s 93, 109, and 11)</p> <p>Findings include:</p> <p>1. The "PRESSURE PREVENTION GUIDELINES" policy was provided by the Director of Nursing on 2/17/11 at 12:00 p.m. This current policy indicated the following:</p> <p>"Purpose: To maintain good skin integrity and avoid development of pressure ulcers.</p> <p>...Hygiene          ...Inspect the skin daily during are for signs of breakdown or changes to the skin.          ...Activity/Mobility          ...Elevate heels off the bed-avoid use of [heel protectors]          ...Nutrition          ...Monitor nutrition and hydration status; if inadequate, assess labs and obtain</p>			F0314	<p>1. Resident #51, #93, #109, and #11 had their wounds assessed by the wound certified clinical support at the time of survey and treatments and interventions changed to appropriate for the resident's assessment and types of wounds.2. Current residents all had baseline risk assessments done at the time of survey and interventions instituted to address their risk factors. Skin sweeps were completed at the time of survey.3. Staff will be in serviced on the prevention of pressure areas and the appropriate treatment of wounds. Baseline skin assessments have been completed and the assessments will be updated and reviewed in CAR with any change of condition or weekly if the resident triggers for CAR. Weekly skin assessments will be completed on all residents by the licensed staff with one shower weekly. The staff will insure that measures are in place with their rounds completed with their hourly rounding.4. The DHS/designee will monitor the interventions daily with the CRCA assignment sheet and direct observation as part of the ongoing QA process. Skin sweeps will be conducted weekly until 0% of avoidable in-house wounds are accomplished for 4 weeks then every other week for 4 weeks, then monthly on an indefinite basis. The DHS/designee will review all new</p>		03/23/2011

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	<p>dietary consultation....."</p> <p>The "Selection of Therapeutic Support Surfaces Guidelines" policy was provided by the Administrator on 2/17/11 at 12:00 p.m. This current policy indicated the following:</p> <p>"Purpose: To provide an appropriate therapeutic surface when determined to be medically necessary by the interdisciplinary team and/or the physician for prevention and healing of skin impairment.</p> <p>Procedure and considerations: ...6. Because heels and elbows have relatively little surface area, it is difficult to redistribute pressure on these two surfaces. It is important to pay particular attention to reducing the pressure on these areas....."</p> <p>The "Quick-Reference Operating Instructions Sapphire 1100 Alternating Low-Air-Loss Mattress System" policy was provided by the Assistant Director of Nursing on 2/18/11 at 11:30 a.m. This current policy indicated the following:</p> <p>...* Avoid use of linen between patients and mattress * Use only necessary linen for</p>				<p>admits for appropriate interventions to address risk factors as part of the ongoing QA process. The results will be reviewed monthly in QA for six months and then at least quarterly.5. 3/23/11</p>		

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	incontinence management/patient comfort * Top cover will help minimize friction and shear...."  The inservice "PROVIDING COMPASSIONATE CARE" was provided by the Assistant Director of Nursing (ADON) on 2/18/11 at 10:35 a.m. In an interview at this same time, the ADON indicated the inservice was conducted on a 1 on 1 basis or by the CNA reading the information confirmed by the CNA's signature. This inservice indicated the following:  PROPER PERICARE - KEEP RSD'S (RESIDENTS) CLEAN AND DRY  ...-ALL INCONTINENT RSD'S TO BE PROPERLY CLEANSED PRIOR TO APPLYING CLEAN BRIEF  ...SPECIALTY MATTRESSES  - BED PADS ARE NOT TO BE USED!!!!!!!  - RSD'S WHO WEAR BRIEFS ARE NOT TO USE BEDPADS  ...WOUND CARE  ...- IF TREATMENTS ARE SOILED OR						

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	OFF REPORT TO NURSE SO THEY CAN REAPPLY...."  2. On 2/15/11 from 1:47 p.m. to 2:10 p.m., Resident #51's dressing change to an area on the resident's right buttock was observed. The resident was observed lying on top of a blanket folded in quarters with an incontinent pad on top of the blanket and a brief on. She was complaining of her "bottom" hurting. In preparation, LPN #13 was observed to wet a 2 by 2 gauze pad with normal saline. As the resident was positioned, LPN #13 indicated the resident was incontinent of urine and changed her brief. No peri-care was observed when the brief was changed. The resident's open area was pink around the open area with a yellow/white open area. As LPN #13 indicated she was cleansing the area, she was observed to pat the open area with the 2 by 2 wet gauze, turn it over and pat the open area again with the same gauze pad, then, patted it dry in the same manner with a dry 2 by 2 gauze. After opening a 4 by 4 gauze package, she applied 2 pieces of the silver alginate over the open area followed by the opened 4 by 4 gauze pad, and then applied the op site (a type of tape) to one side of the dressing. After turning the resident to the other						

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	<p>side, LPN #13 with the same gloves was observed to use her gloved finger to push the silver alginate back up into the open side of the dressing as it had started to fall out when the resident was turned. She then applied the other piece of op site to the dressing. She then proceeded to remove the soiled incontinent pad under the resident and indicated the resident had been incontinent of urine again. The resident's brief was again changed with no peri-care observed as the resident was repositioned with a folded blanket in half under her.</p> <p>On 2/17/11 at 755 a.m. and at 8:50 a.m., Resident #51 was observed up in her wheelchair. She indicated her "bottom" was hurting.</p> <p>On 2/17/11 from 8:50 a.m. to 9:10 a.m., Resident #51's personal care was observed. After the resident was transferred to her bed by CNA #19 and CNA #42, the resident's pants were removed. As they turned the resident, the resident's treatment dressing on her buttocks was observed with no date on it as the brief was removed. The dressing was observed with slight reddish drainage visible under the op site. CNA #19 and CNA #42 indicated the resident had been incontinent of urine with a small amount</p>						

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	<p>of loose bowel movement. CNA #42 indicated the resident was constantly incontinent of urine anytime the resident was moved. With gloved hands CNA #19 cleansed the resident's rectal area. No front peri-care was observed completed. At this same time during an interview, CNA #42 indicated they try to keep the resident dry especially in her abdominal folds and would use wipes to clean her unless it is "too bad" then they would use washcloths. Also, at this same time during an interview, CNA #19 indicated they try to keep her as dry as possible by checking her before and after she eats and before and after therapy.</p> <p>On 2/17/11 at 11:00 a.m. during an interview, the Assistant Director of Nursing (ADON) indicated with the Sapphire Mattress used by Resident #51 the linen preferred was 1 sheet and or 1 paper chux. At this same time with the ADON present, the resident, who was in her wheelchair, indicated she had a "sore bottom." The resident had a folded full sheet on the bed presently. The ADON instructed CNA #19 to remove the sheet from the bed, which was done. At this same time the ADON assisted CNA #19 and the resident was transferred back to her bed. On this same day at 11:20 a.m., LPN #44 entered to do the resident's</p>						

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	<p>             dressing change. The resident's open area on her right buttock was observed with red drainage around the bottom of her open area. As the resident's dressing change was completed, the corner of the silver alginate was observed to have slipped out from 1 side of the 4 by 4 gauze covering it and was taped in this position by LPN #44 to complete the dressing change.           </p> <p>             On 2/18/11 at 12:40 p.m. during an interview, RN #45 indicated she had completed Resident #51's initial skin measurement. She indicated the area was a small area as measured on the skin sheet on 1/31/11. At this same time during an interview, the Director of Nursing (DON) indicated when she had measured the area on 2/07/11, the area was "like 3 areas merging."           </p> <p>             On 12/18/11 at 2:20 p.m. with the Nursing Consultant, the opened area on the right upper buttock was observed with white/yellowish center surrounded by redness around the majority of the open area, but with a purplish color noted on the bottom of the open area.           </p> <p>             On 2/21/11 at 2:45 p.m. during an interview, the ADON and the DON both indicated when cleansing an open wound,           </p>						

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	<p>one should cleanse from the inside to the outside in a circular motion.</p> <p>Resident #51's record was reviewed on 2/17/11 at 9:55 a.m. The resident's diagnoses included, but were not limited to, diabetes, anemia, arthritis, history of scoliosis, hypertension, and congestive heart failure.</p> <p>The physician order, dated 1/25/11, was for a specialty overlay mattress and Xenaderm (skin protectant) to buttocks 2 times a day.</p> <p>The physician order, dated 1/26/11, was for the treatment of calamizine every shift to the right upper buttock.</p> <p>The physician order, dated 2/07/11, was to cleanse the "coccyx" wound with normal saline, apply silver alginate dressing, and cover with 4 by 4 gauze and op site every 3 days and as needed for soilage and/or dislodgement. Check placement every shift.</p> <p>The physician order, dated 2/07/11, was to discontinue the Roho overlay and to place a sapphire mattress on the resident's bed.</p> <p>No information was indicated in the nurse's notes from 1/25/11 to 2/08/11 concerning the resident's coccyx until a new physician order was received on 2/02/11.</p>						

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	<p>The "ASSESSMENT REVIEW AND CONSIDERATIONS," dated 1/25/11, indicated in the "Skin breakdown risk potential" category this resident had the following risk factors, which included mobility impairment, incontinence/moisture, and past history with an individualized care plan initiated to address the identified risk factors and minimize the risk of skin breakdown.</p> <p>The "Nursing Admission Assessment &amp; Data Collection," dated 1/26/11 at 10:00 a.m., indicated a 0.3 cm (centimeter) by 0.2 cm open area on the right upper buttock. The "Skin Plan of Care" indicated no information concerning preventive measures.</p> <p>The "Resident Care Plan," dated 1/25/11, indicated the problem was bowel and bladder incontinence. The goals included, but were not limited to, be free of skin breakdown related to incontinence and to be clean and dry. The interventions included, but were not limited to, provide incontinence care after each episode of incontinence.</p> <p>The "Resident Care Plan," dated 1/25/11, indicated the problem was potential for alteration skin integrity. The goal was the</p>						

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	<p>resident was not to develop alteration in skin integrity. The interventions included, but were not limited to, assess/record changes in skin status and provide/monitor effectiveness of pressure relieving or reduction devices as pressure reducing mattress.</p> <p>The "PRESSURE/STASIS/ARTERIAL/DIABETIC ULCER ASSESSMENT" indicated the following:</p> <p>On 1/26/11 the initial identification of the right buttock pressure area was red in color and measured 0.3 centimeters (cm) by 0.2 cm with no depth.</p> <p>On 1/31/11 the stage II pressure area was red and measured 0.5 cm by 0.6 cm with no depth.</p> <p>On 2/07/11 the area was indicated as a stage IV and measured 7.0 cm by 5.0 cm with a 0.1 depth. The wound bed was indicated with 3 areas of dark purple with 80% yellow and 10% pink. There was a small amount of exudate indicated.</p> <p>On 2/12/11 the stage IV pressure area measured 6.0 cm by 5.0 cm with no depth identified. The wound bed was indicated as pink.</p> <p>On 2/14/11 the stage IV pressure area measured 6.7 cm by 4.5 cm with 0.1 cm depth. The wound bed was indicated as 100% thick yellow slough.</p>						

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F0314 SS=G	<p>3. The record for Resident # 93 was reviewed on 2/17/11 at 9:30 a.m.</p> <p>The resident was admitted 9/3/10 with a right tibia fracture.</p> <p>A nursing admission assessment dated 9/3/10 indicated the resident's skin was clear of red or open areas.</p> <p>The resident's plan of care on this form indicated the resident's heels were to be elevated off surfaces.</p> <p>A 9/16/10 "Skin Impairment Circumstance, Assessment and Intervention" form indicated the resident had an unstageable pressure ulcer on his right heel. The form indicated the area was a blister with a discolored middle.</p> <p>A 9/16/10, "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment" form indicated the resident had a 4.3 centimeter (cm) by 4 cm blister with a discolored area in the center that measured 2.4 cm by 1.5 cm on the right heel.</p> <p>A 9/23/10 assessment indicated the right heel area was 3 cm by 3.5 cm and was 60 % yellow and 20 % dark necrotic.</p> <p>There was not documentation in the</p>		F0314	<p>1. Resident #51, #93, #109, and #11 had their wounds assessed by the wound certified clinical support at the time of survey and treatments and interventions changed to appropriate for the resident's assessment and types of wounds.2. Current residents all had baseline risk assessments done at the time of survey and interventions instituted to address their risk factors. Skin sweeps were completed at the time of survey.3. Staff will be in serviced on the prevention of pressure areas and the appropriate treatment of wounds. Baseline skin assessments have been completed and the assessments will be updated and reviewed in CAR with any change of condition or weekly if the resident triggers for CAR. Weekly skin assessments will be completed on all residents by the licensed staff with one shower weekly. The staff will insure that measures are in place with their rounds completed with their hourly rounding.4. The DHS/designee will monitor the interventions daily with the CRCA assignment sheet and direct observation as part of the ongoing QA process. Skin sweeps will be conducted weekly until 0% of avoidable in-house wounds are accomplished for 4 weeks then every other week for 4 weeks, then monthly on an indefinite basis. The DHS/designee will review all new</p>		03/23/2011	

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	<p>record indicating the area was observed or assessment prior to 9/16/10.</p> <p>4. The record for Resident # 109 was reviewed on 2/15/11 at 3:40 p.m.</p> <p>A 2/14/11 pressure ulcer assessment indicated the resident had an unstageable area on the right gluteal that was 5.5 cm by 4.5 cm. The area was 60 % dark brown, 30 % slough and 10% red.</p> <p>During a dressing change observation on 2/15/11 at 1:50 p.m. with LPN # 26, the LPN donned gloves and removed the soiled dressing. She then cleaned the wound. The wound was observed to appear as the measurements and description above. The nurse then removed her gloves and washed her hands for less than 8 seconds. She then donned gloves and applied skin prep to the wound edges. Then, with a gloved hand, she placed the Santyl (medication) onto her gloved finger and wiped it into the wound bed. She then removed her gloves and applied the foam dressing and tape.</p> <p>5. The record for resident # 11 was reviewed on 2/15/11 at 1:25 p.m.</p> <p>A wound sheet dated 2/14/11 indicated the resident had a stage III ulcer to his left</p>				<p>admits for appropriate interventions to address risk factors as part of the ongoing QA process. The results will be reviewed monthly in QA for six months and then at least quarterly.5. 3/23/11</p>		

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	heel.  During a dressing change observation on 2/16/11 at 8:10 a.m., LPN # 26 removed the soiled dressing. The area was observed to be approximately 2 cm by 1 cm with a yellow wound bed. LPN # 26 then cleaned the wound, removed her gloves, washed her hands then donned gloves. She then applied skin prep to the wound edges. She then placed a small amount of Santyl onto her gloved finger and wiped it into the wound bed and applied the dressing.  On 2/21/11 at 9 a.m., during interview, LPN # 26 indicated she should have used a Q-tip to apply the Santyl. She indicated she did not have a Q-tip available, they had spilled out in her treatment cart.  3.1-40(a)(1) 3.1-40(a)(2)						

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F0315 SS=D	<p>Based on record review, observation and interview the facility failed to ensure anchored catheter bags and tubing were positioned in a manner to prevent the possibility of contamination for 3 of 3 residents reviewed with anchored catheters in a sample of 17. (Resident # 93, # 109 and # 108)</p> <p>Findings include:</p> <p>1. An undated policy titled "Guidelines for Urinary Catheter Care" was provided by the Administrator on 2/21/11 at 8 a.m., and deemed as current. The policy indicated: "Purpose: To prevent infection of the resident's urinary tract...4. The urinary drainage bag should be held or positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder...11. Be sure the catheter tubing and drainage bag are kept off the floor...."</p> <p>2. The record for Resident # 93 was reviewed on 2/17/11 at 9:30 a.m.</p> <p>Current diagnoses included, but were not limited to, urinary retention.</p> <p>Admission orders dated 9/3/10 indicated the resident had a supra-pubic anchored</p>			F0315	<p>1. Residents #93, #109, and #108 have been assessed and the assessment reviewed with the physician. There were no negative outcomes.2. Current residents with catheters will be assessed for any outcomes from the alleged deficient practice. Any outcomes will be reviewed with the physician and appropriate interventions implemented.3. Clinical staff will be in serviced on proper placement of catheter tubing during transfer and transport.4. The DHS/designee will monitor through direct observation placement of tubing daily until 100% compliance is achieved, then at least weekly on an indefinite basis. Results will be reviewed at the QA meeting monthly for six months and then at least quarterly.5. 3/23/11</p>		03/23/2011

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	<p>catheter and was on Cipro 500 milligrams for the treatment of a urinary tract infection.</p> <p>During the initial tour on 2/15/11 at 9:50 a.m. with the Assistant Director of Nursing, Resident # 93 was in his wheel chair in his room. His anchored catheter tubing on the floor under his wheelchair. At that time during interview, the Assistant Director of Nursing indicated the tubing should not be on the floor.</p> <p>On 2/15/11 at 1:05 p.m., the resident was wheeling himself out of the dining room. His anchored catheter tubing was dragging the floor under his wheelchair.</p> <p>During a personal care observation of Resident # 93 on 2/15/11 at 1:35 p.m., CNA # 22 with ungloved hands removed the resident's anchored catheter bag from the dignity cover and gave it to CNA # 23 who without gloves placed the bag and tubing into the resident's lap above the level of the bladder. The CNAs then proceeded to transfer the resident by hooyer lift to his recliner.</p> <p>3. The record for resident # 109 was reviewed on 2/15/11 at 3:40 p.m.</p> <p>A plan of care dated 2/15/11 indicated the</p>						

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	<p>resident was at risk for a urinary tract infection due to an indwelling anchored catheter.</p> <p>During a personal care observation of Resident # 109 on 2/15/11 at 1:45 p.m., CNA # 22 with ungloved hands, placed the resident's anchored catheter bag and tubing the resident's chest, above the level of the bladder. CNA # 22 and # 23 transfer the resident to the bed by hooyer lift. During the transfer the anchored catheter tubing and the resident's oxygen tubing were tangled together. After the resident was placed in bed, both CNA's donned gloves without washing their hands and completed the resident's care.</p>						

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F0315 SS=D	<p>4. On 2/15/11 at 10:30 a.m. during the initial tour, Resident #108 was observed sitting on the side of his bed. His foley catheter bag and tubing were observed on the floor. Cloudy, yellow urine with white sediment was observed in the foley catheter tubing.</p> <p>On 2/15/11 at 5:55 p.m., Resident #108 was observed sitting on the side of the bed with his foley catheter tubing observed on the floor. Yellow, cloudy urine with white sediment was observed in the foley catheter tubing.</p> <p>On 2/17/11 at 10:30 a.m., Resident #108 was observed sitting on the side of the bed with his foley catheter tubing on the floor. Cloudy, yellow urine was observed in the foley catheter tubing at this same time.</p> <p>On 2/18/11 at 10:35 a.m. during an interview, the Assistant Director of Nursing indicated she had recently had an inservice concerning the foley catheter issues. She indicated she had inserviced 1 to 1 or by having the CNA read the inservice and sign to verify they had read and understood the information.</p> <p>This inservice "PROVIDING COMPASSIONATE CARE" was provided by the Assistant Director of</p>			F0315	<p>1. Residents #93, #109, and #108 have been assessed and the assessment reviewed with the physician. There were no negative outcomes.2. Current residents with catheters will be assessed for any outcomes from the alleged deficient practice. Any outcomes will be reviewed with the physician and appropriate interventions implemented.3. Clinical staff will be in serviced on proper placement of catheter tubing during transfer and transport.4. The DHS/designee will monitor through direct observation placement of tubing daily until 100% compliance is achieved, then at least weekly on an indefinite basis. Results will be reviewed at the QA meeting monthly for six months and then at least quarterly.5. 3/23/11</p>		03/23/2011

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	<p>Nursing (ADON) on 2/18/11 at 10:35 a.m. This inservice indicated the following:</p> <p>"...CATHETERS - BAGS TO BE COVERED AT ALL TIMES</p> <p>- TUBING NOT TO BE ON FLOOR...."</p> <p>On 2/18/11 at 10:40 a.m. during an interview, the Director of Nursing indicated Resident #108 was educated yesterday concerning his foley catheter. She also indicated she had not tried any other alternative for the resident, for example, a leg bag.</p> <p>Resident #108's record was reviewed on 2/17/11 at 8:20 a.m. The resident's diagnoses included, but were not limited to, diabetic mellitus. The admission minimum data set assessment, dated 12/28/10, indicated the resident was able to make his own decisions. He did have an indwelling foley catheter.</p> <p>The physician order, dated 12/31/10, was Macrobid 100 milligrams every 12 hours for 7 days for a urinary tract infection.</p> <p>The laboratory study for the urine culture, dated 12 31/10, indicated the growth of Pseudomonas Aeruginosa.</p>						

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	<p>The "Resident Care Plan", dated 12/14/10, indicated the problem of "indwelling catheter" with "Res (resident) will move catheter bag. He has been educated on infex (infection) control But continues to move bag causing tubing to be on floor."</p> <p>No information was indicated the resident had been educated concerning the identified problem of the indwelling catheter.</p> <p>On 2/18/11 at 8:00 a.m., the DON left nurse's notes, dated 2/17/11, where the resident had been educated concerning the foley catheter.</p> <p>3.1-41(a)(2)</p>						

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F0325 SS=G	<p>Based on record review, observation and interview, the facility failed to identify, assess, and implement interventions to prevent weight loss and prevent the possibility of weight loss for 7 of 14 residents reviewed for weight loss in a sample of 17. (Resident # 11, # 65, # 104, # 63, # 83, # 4, and # 20) Resident # 11 experienced a 45.4 pound weight loss which was a 21% loss in 90 days, without intervention.</p> <p>Finding include:</p> <p>1. An undated policy titled "Nutritional Management Guidelines" was provided by the Nurse Consultant on 2/18/11 at 1:20 p.m., and deemed as current. The policy indicated: "Purpose: To ensure all residents are assessed for nutritional needs with interventions implemented as appropriated to maintain proper nutritional balance...2. Nutritional assessment will be completed quarterly and as needed thereafter...5. Residents identified to be a nutritional risk may include but are not limited to: a. Significant unplanned weight loss 1. 5 % in one month, 7.5 % in three months...b. Identified with chronic weight loss yet not meeting the above criteria. c. Determined to be at risk by nutritional assessment. d. Significant risk factors...f.</p>			F0325	<p>1. Resident#11, #65, #104, #63, #83, #4 and #20 have had their weight loss assessed and reviewed by their physicians and appropriate interventions instituted as per their orders.2. Current resident's weights will be reviewed by the clinical support and the interdisciplinary team. Any resident identified at risk or triggering significant weight loss will have weight loss reviewed with their physician and interventions implemented as ordered.3. Licensed staff will be in serviced on signs and symptoms of weight loss and interventions. The weight histories of the residents will be reviewed at the CAR meeting monthly for all campus residents and weekly for the "at risk" residents as identified by their assessments/consumption records.4. The DHS/designee will review the weights monthly for triggered weight loss as part of the ongoing QA process and will continue indefinitely. The DHS/designee will review the "at risk" residents weekly in the CAR meeting as part of the ongoing QA process and will continue indefinitely. Results will be reviewed monthly in QA for six months and then at least quarterly.5. 3/23/11</p>		03/23/2011

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	<p>Compromised lab values 1. Serum albumin below 3.5...Approaches to be taken are, but not limited to: d. Implementation of additional caloric products 1. Fortified foods with meals and for snacks 2. High caloric snacks between meals 3. In-house nutritional supplements per physician order 4. Med pass program per physician order...."</p> <p>2. An undated policy titled "Guidelines for Weight Tracking" was provided by the Administrator on 2/17/11 at 12 p.m. and deemed as current. The policy indicated: "Purpose: To ensure resident weight is monitored for weight gain and/or loss to prevent complications arising from compromised nutrition...3. The facility dietician will review the resident's nutritional status, ideal body weight and current weight to implement a nutritional program when warranted...8. The...dietician shall be notified of a weight variance of &gt;[greater than] 5 %...."</p> <p>3. A 11/07 policy titled "Clinically At Risk (CAR) Program Guidelines" was provided by the Administrator on 2/17/11 at 12 p.m., and deemed as current. The policy indicated: "...Criteria for residents who will be followed by the CAR team: Residents who have experienced a significant weight change. Significant</p>						

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FORM APPROVED

OMB NO. 0938-0391

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	<p>weight change is defined as a variance of 2 % in 7 days, 5 % in 30 days, 7.5 % in 90 days...5. The CAR team will review current interventions and potential changes and make recommendations based on individual resident's needs...6. For those interventions that do not require a physician's order, i.e. dietary/nursing/clinical measures, the responsible clinician will take the appropriate action for implementation...."</p> <p>4. The record for Resident # 11 was reviewed on 2/15/11 at 1:25 p.m.</p> <p>Current diagnoses included, but were not limited to, pernicious anemia, Diabetes Mellitus, renal failure, and dementia.</p> <p>A 1/28/11 Significant Change Minimum Data Set Assessment (MDS) failed to indicate the resident had had weight loss.</p> <p>The record lack a plan of care for weight loss until 2/17/11.</p> <p>The resident was readmitted to the facility on 11/11/10. A "Nutritional Assessment" dated 11/15/10 indicated the resident had an actual weight of 216.4 pounds. The assessment indicated the resident consumed 88.7 % of meals and had an albumin of 2.9 (Normal range - 3.3 to 4.5)</p>						

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	<p>on 11/1/10.</p> <p>A "Vital Signs and Weight Record" indicated the following weights:</p> <p>11/17/10: 206.1</p> <p>12/2/10: 207.4</p> <p>12/9/10: 208.4</p> <p>12/16/10: 195.2 Physician and family notified</p> <p>12/20/10: 190.2</p> <p>1/3/11: 186 Physician and family notified</p> <p>1/11/11: 178.6 Physician and family notified</p> <p>2/9/11: 171.8 Physician and family notified</p> <p>The above form had an identified place for dietary to be notified. This area of the form was blank.</p> <p>Physician progress notes dated 12/2/10, 12/6/10, 12/13/10, and 1/24/10 did not mention the resident's weight loss.</p> <p>CAR (Clinically at Risk) meeting notes dated 12/2/10 indicated the resident weighed 207.4 pounds and consumed 63% of meals. On 12/9/10, weight was 208.4 with the resident consuming 66 % of meals. On 12/16/10 the weight was recorded as 195.2 pounds with the resident consuming 70 % of meals. On</p>						

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	<p>12/22/10 the weight was recorded at 190.2 pounds, no consumption was recorded. On 12/29/10 the weight was recorded at 192 with no consumption and on 1/5/11 the weight was recorded at 186 pounds. In the area of the form that indicated "Resident continues with weight instability. See below for updated interventions" did not mention weight loss or any interventions to be implemented. Between 12/2/10 and 1/5/11 the resident lost 21.4 pounds which was a 10.3 % weight loss. The Certified Dietary Manager was not in attendance at the CAR meeting 12/2/10-12/29/10. On 2/18/11 at 10:30 a.m., during interview, the Certified Dietary Manager # 27 indicated she was on sick leave between 12/2-29/10. She did sign the CAR note on 1/5/11 as being in attendance. During the above interview, she indicated she did not know who was to communicate to the dietician during her absence. She further indicated, the resident should have been on the list to see the dietician due to his weight loss. On 12/20/10 Juven (protein supplement) was added for wound healing due to open areas on his bottom.</p> <p>A CAR note dated 1/12/11 indicated the resident weighed 178.6 pounds and consumed 50 % of meals, still no interventions are implemented for the</p>						

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	<p>weight loss.</p> <p>A nursing note dated 1/15/11 at 2:30 p.m., indicated the resident was pale and lethargic.</p> <p>A nursing note dated 1/5/11 at 3:40 p.m., indicated the physician was called at the insistence of the daughter due to the resident's change in cognition and a moist cough.</p> <p>A nursing note dated 1/15/11 at 3:50 p.m., indicated the resident could not feed himself and was fed by staff.</p> <p>On 1/15/11 the resident was admitted to the hospital with acute renal failure. A 1/17/11 hospital progress note indicated the resident had an albumin of 1.9 (low) which suggested poor nutritional status and protein calorie malnutrition with weight loss. The family declined a gastrostomy tube and speech had suggested a special diet. A 12/7/10 laboratory report indicated the resident's albumin was 3.4 which was within normal limit.</p> <p>A 1/16/11 (name of hospital) "Nutritional Assessment Form" indicated the resident had lost 40 pounds in 2 months. The form indicated the resident was placed on sugar</p>						

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	<p>free vanilla health shakes with breakfast and dinner, sugar free pudding with breakfast, oatmeal with breakfast and brown sugar portion with breakfast. The form indicated the resident had significant weight loss of 19 % in 2 months which the daughter confirmed, and the resident very likely had protein-calorie malnutrition.</p> <p>The resident was readmitted to the facility on 1/20/11 with a pureed diet with nectar thick liquids. No supplements or other dietary interventions were implemented except Juven. (protein supplement)</p> <p>A 1/24/11 nursing assessment indicated the resident weighed 178.6 pounds.</p> <p>The resident was admitted to hospice care on 1/27/11. On 2/21/11 at 11:10 a.m. during an interview with (name of hospice) RN, she indicated the resident was started on Decadron (steroid) on 2/4/11 for appetite stimulation.</p> <p>During an interview with Registered Dietician on 2/17/11 at 2:50 p.m., she indicated she was not aware the resident had significant weight loss until January 27, 2011. She indicated she had not seen the resident until this day.</p>						

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	A 2/17/11 "Quarterly -Weekly Nutrition Progress Overview" indicated the resident had a 45.4 pound weight loss which was 21 % in 90 days. At this time, she had recommended sugar free Med Pass 60 milliliters three times daily due to significant weight loss.						

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F0325 SS=G	<p>5.) Resident #65's record was reviewed on 2/15/11 at 11:51 a.m.</p> <p>Resident #65's current diagnoses included, but were not limited to, dementia and non-insulin dependent diabetic. Resident #65 resided on a secured dementia unit.</p> <p>Resident #65 had a current 2/11 physician's order for a regular diet.</p> <p>Resident #65 was admitted to the facility as a residential, assisted living dementia needs</p>			F0325	<p>1. Resident#11, #65, #104, #63, #83, #4 and #20 have had their weight loss assessed and reviewed by their physicians and appropriate interventions instituted as per their orders.2. Current resident's weights will be reviewed by the clinical support and the interdisciplinary team. Any resident identified at risk or triggering significant weight loss will have weight loss reviewed with their physician and interventions implemented as ordered.3. Licensed staff will be in serviced on signs and symptoms of weight loss and interventions. The weight histories of the residents will be reviewed at the CAR meeting monthly for all campus residents and weekly for the "at risk" residents as identified by their assessments/consumption records.4. The DHS/designee will review the weights monthly for triggered weight loss as part of the ongoing QA process and will continue indefinitely. The DHS/designee will review the "at risk" residents weekly in the CAR meeting as part of the ongoing QA process and will continue indefinitely. Results will be reviewed monthly in QA for six months and then at least quarterly.5. 3/23/11</p>		03/23/2011

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	<p>resident, on 8/3/09. Her weight at the time of her admission was 276 pounds. She was not on a planned weight loss during her stay in the residential area of the facility.</p> <p>Resident #65 was admitted to the skilled nursing area of the facility on 2/9/11. At this time, Resident#65's weight was 230 pounds (a 46 pound unplanned weight loss while living on the Alzheimer's residential unit).</p>						

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	<p>Resident #65 had a current 2/9/11 physician's order for a regular diet.</p> <p>Resident #65 had a 2/9/11 "Nursing Admission Assessment &amp; Data Collection" assessment form which indicated the resident was dependent on assistance when dining. The assessment did not address her 46 pound weight loss in a two year period.</p> <p>Resident #65 had a current, 2/9/11,</p>						

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	<p>admission nutritional care plan problem due to dementia and diabetes. An approach to this problem was to provide the resident a diet per physician's order.</p> <p>Review of the 2/16/11 breakfast menu, which was provided by the Food Services Supervisor on 2/15/11 at 12:12 p.m., indicated residents with regular diets were menued to receive:</p> <p>choice of cereal choice of eggs</p>						

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	4 bacon slices 1 slice of wheat toast 6 ounces of a juice of choice 8 ounces of milk coffee/tea if desired  During a 2/16/11, 8:28 a.m. breakfast meal observation, Resident #65 was served 2 glasses of water, 1 piece of toast and 2 strips of bacon. Resident #65 was not served an egg nor an alternative protein as a replacement for the eggs. Resident #65 ate her bacon very quickly, then her toast. It took her 2						

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	<p>minutes to eat all the food served to her. She then took her finger and wiped the crumbs from her plate and licked the crumbs from her finger.</p> <p>During a 2/16/11, 8:38 a.m., interview, cook #35 indicated she did not serve Resident #65 eggs, because the resident did not like eggs. She additionally indicated she never served Resident #65 eggs or a replacement for eggs because, "I can't get much out of her when I ask her what she wants."</p>						

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	<p>During a 2/16/11, 8:39 a.m., observation, a protein replacement was requested and blueberry yogurt was served to Resident #65. Resident #65 ate 100% of the blueberry yogurt.</p> <p>During a 2/16/11, 12:45 p.m. interview, Resident #65's family indicated the resident had a good appetite and had always eaten eggs when she lived at home.</p> <p>6.) A review of the</p>						

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	<p>2/15/11, lunch menu, which was provided by the Food Services Supervisor on 2/15/11 at 12:12 p.m., indicated the following:</p> <p>all diet types, with the exception of pureed, where menued to receive bread in some form, either as a roast beef sandwich (2 slices) for finger food's diets or as a "Roast Beef Manhattan" (1 slice) for regular, no added salt, carbohydrate controlled and mechanical soft diets.</p>						

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	7.) During a 2/15/11, 12:46 p.m., interview, Cook #35 indicated she had prepared the meal trays which were served in the Legacy skilled Alzheimer's, dementia secured unit. She indicated she had ran out of bread. She had not served a bread alternate, such as a bun or crackers. She had not called the main kitchen to request additionally bread and she had not notified her supervisor regarding the bread shortage. She indicated she did not know what to						

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	<p>do if she ran out of a food item.</p> <p>8.) Resident #4's record was reviewed on 2/18/11 at 9:15 a.m.</p> <p>Resident #4's current diagnoses included, but were not limited to, dementia and hypertension. Resident #4 resided on a secured dementia unit.</p> <p>Resident #4 had a current, 2/11, physician's order for a mechanical soft, honey thicken</p>						

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	<p>liquid, finger foods diet.</p> <p>Resident #4 had a current, 8/30/10 care plan problem regarding the potential for an alteration in nutritional status. An approach to this problem was to serve a diet as ordered.</p> <p>Resident #4's weight history was the following:</p> <p>8/10-140.0 pounds</p> <p>9/10-142.6 pounds</p> <p>10/10-138.6 pounds</p> <p>11/10-137.8 pounds</p> <p>12/10-136.0 pounds</p> <p>1/11-136.0 pounds</p>						

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	<p>2/11-135.0 pounds</p> <p>Resident #4 weight record indicated she was having a slow gradual loss of weight, resulting in a weight loss of 3.57% (5 pounds) in six months.</p> <p>Resident #4 had a 4/14/10 clinically at risk note which indicated she would be served finger foods, when a mechanical soft diet would permit, in order to encourage the resident to pick up the food with her hands and eat. The decision was made due</p>						

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	<p>to the resident attempting to pick up food items.</p> <p>During a 2/15/11, 12:15 p.m. to 12:40 p.m., observation of meal service Resident #4 was served ground roast beef, mashed potatoes and gravy, greens and cherry pie. Resident #4 was not served bread.</p> <p>9.) Resident #63's record was reviewed on 2/18/11 at 10:00 a.m.</p> <p>Resident #63's current diagnoses, included, but</p>						

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	<p>were not limited to, dementia, depression and anxiety. Resident #63 resided on a secured dementia unit.</p> <p>Resident #63 had a current, 2/11, physician's order for a regular diet with ground meat.</p> <p>Resident #63 had a current, 8/30/10, care plan problem regarding a potential for alteration in nutritional status due to dementia. An approach to this problem was to serve the diet as ordered.</p>						

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	<p>During a 2/15/11, 12:15 p.m. to 12:40 p.m., observation of meal service Resident #63 was served ground roast beef, mashed potatoes and gravy, greens and cherry pie. Resident #63 was not served bread.</p> <p>10.) Resident #20's record was review on 2/18/11 at 9:30 a.m.</p> <p>Resident #20's current diagnoses include, but were no limited to, dementia and anxiety. Resident #20 resided on a secured dementia unit.</p>						

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	<p>Resident #20 had a current ,2/11, physician's order for a regular diet.</p> <p>Resident #20 had a current, 12/27/10, care plan problem regarding the potential for an alteration in nutritional status due to dementia. An approach to this problem was to serve a diet as ordered.</p> <p>Resident #20's weight history was the following:</p> <p>12/10-151 pounds</p>						

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	<p>1/11-146.5 pounds 2/11-147 pounds Resident #20 has had a 4 pound-2.64% weight loss since admission.</p> <p>During a 2/15/11, 12:15 p.m. to 12:40 p.m., observation of meal service Resident #20 was served roast beef, mashed potatoes and gravy, greens and cherry pie. Resident #20 was not served bread.</p> <p>11.) Resident #83's record was reviewed on 2/18/11 at 10:15 a.m.</p>						

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	<p>Resident #83's current diagnoses, included, but were not limited to, organic mental syndrome, diabetes and depression. Resident #83 resided on a secured dementia unit.</p> <p>Resident #83 had current 2/11, physician's orders for a mechanical soft diet with nectar thickened liquids.</p> <p>Resident #83 had a current, 9/1/10, care plan problem regarding the risk for alteration in nutritional status due to</p>						

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	<p>dementia. An approach to this problem was to serve a diet as ordered.</p> <p>Resident #83's weight history was as follows: 8/10-178.60 pounds 9/10-176.0 pounds 10/10-176.40 pounds 11/10-168.80 pounds 1/11-164.0 pounds 1/11-161.20 pounds Resident #83 had a 17.4 pound- 9.4% weight loss in 6 months.</p> <p>During a 2/15/11, 12:15 p.m. to 12:40 p.m., observation of meal service Resident #83 was</p>						

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	<p>served ground roast beef, mashed potatoes and gravy, greens and cherry pie. Resident #83 was not served bread.</p> <p>12.) Resident #104's record was reviewed on 2/15/11 at 11:50 a.m.</p> <p>Resident #104's current diagnoses included, but were not limited to, dementia, anorexia, and depression. Resident #104 resided on a secured dementia unit.</p> <p>Resident #104 had a current, 2/11, physician's</p>						

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	<p>order for a regular finger food diet.</p> <p>Resident #104 had a , 2/2/11,current care plan problem regarding his potential for weight loss because he had a diagnoses of anorexia. Approaches to this problem included, but were not limited to, provided dietary supplements as needed and encourage family to bring food resident enjoys.</p> <p>Resident #104's weight history was as follows:</p>						

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	<p>Admission weight 2/19/10-128 pounds 9/6/10-118 pounds 10/2/10-114.8 pounds 11/2/10-114.8 pounds 12/10-110.4 pounds 1/1/11-110 pounds 2/3/11-107.8 pounds Resident #104 had a 10.2 pound-8.6% weight loss in 6 months and a 20.2 pound-15.7% weight loss in one year.</p> <p>During a 2/21/11, 1:35 p.m. interview, the Director of Nursing indicated Resident #104 had a finger food diet order in hopes he would</p>						

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	<p>pick up food and self feed, even while moving about, in order to increase consumption.</p> <p>During a 2/15/11, 12:15 p.m. to 12:40 p.m., observation of meal service Resident #104 was served roast beef, mashed potatoes and gravy, greens and cherry pie. Resident #104 was not served bread.</p> <p>During a 2/15/11, 12:15 p.m. to 12:40 p.m., observation of meal service, Resident #104 showed no interest in his</p>						

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	<p>roast beef, mashed potatoes and gravy and greens. Resident #104 got up from the table multiple times and walked around. Staff members tried to redirect him to his roast beef without success. Resident #104 did not have any item on his tray that he could eat with his fingers or carry as he moved about the unit. With every attempt to redirect, he showed no interest in the roast beef. At 12:25 p.m., a staff member began to serve desserts. An unknown</p>						

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	<p>staff voice asked Resident #104 if he would like cherry pie. Resident #104 went quickly to the dining table and sat down. He was served cherry pie. Resident #104 smiled and ate 100% of his cherry pie within 2 minutes of it being served. As indicated above resident #104's care plan indicated the family should bring in food the resident enjoys. Resident #104 ate the cherry pie with signs of enjoyment. The facility staff in the area did not</p>						

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	<p>offer Resident #104 any additional cherry pie. Resident #104 was not offered any additional cherry pie by the time the meal was concluded.</p> <p>During a 2/17/11, 4:30 p.m. interview, the Director of nursing indicated Resident #104, who was a poor eater and had a diagnoses of anorexia, should have been offered additional cherry pie if he had enjoyed the food item.</p> <p>3.1-46(a)(1)</p>						

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F0328 SS=D	<p>Based on record review, observation and interview, the facility failed to ensure oxygen was administered at the ordered flow rate for 1 of 3 residents observed for oxygen administration (Resident # 109) and failed to ensure licensed personnel initiated oxygen for 2 of 3 residents observed with oxygen in a sample of 17. (Resident # 54 and # 51)</p> <p>Findings include:</p> <p>1. During a personal care observation of Resident # 54 on 2/15/11 at 4:50 p.m., the resident was transferred to her wheelchair. CNA # 30 changed the resident's oxygen tubing from the concentrator to the portable oxygen tank and then set the flow rate of the oxygen on the portable tank to 3 liters.</p> <p>During an interview with CNA # 31 on 2/21/11 at 9 a.m., she indicated the licensed nurses are to fill and set oxygen flow rates.</p> <p>2. The record for Resident # 109 was reviewed on 2/15/11 at 3:40 p.m.</p> <p>Current physician orders for February 2011 indicated an order for oxygen to be administered at 3-4 liters.</p>			F0328	<p>1. Resident # 54, #51, and #109 had their flow rate adjusted at the time of survey. They were assessed and no negative outcomes were noted.2. Current residents with oxygen were assessed and no negative outcomes were noted.3. Clinical staff will be in serviced on the correct administration of oxygen and flow rates. Licensed staff will monitor flow rates during their clinical rounding daily.4. The DHS/designee will monitor flow rates through direct observation at least daily until 100% compliance is achieved, then at least weekly on an indefinite basis. Results will be reviewed at QA monthly for six months and then at least quarterly.5. 3/23/11</p>		03/23/2011

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SS=D	<p>On 2/15/11 at 5:30 p.m., the resident was in her wheelchair in the dining room. The oxygen flow rate was set at 2.5 liters. At that time, the Assistant Director Of Nursing was queried if that was the correct flow rate. At that time, during interview, she indicated she would go check the orders. Within 5 minutes, she returned and indicated the flow rate was at the incorrect rate. She checked the resident's oxygen saturation and set the flow rate to 3 liters.</p> <p>3. On 2/16/11 at 9:25 a.m., Resident #51 was observed up in her wheelchair (w/c). CNA #19 was observed to obtain a portable oxygen tank which was placed on the back of the resident's w/c. After she connected the resident's oxygen up to the tank, CNA #19 was observed to turn the oxygen on after she checked the oxygen flow from the room's oxygen concentrator. At this same time during an interview, CNA #19 indicated she had turned the oxygen flow to 3 liters per minute.</p> <p>On 2/16/11 at 9:30 a.m. during an interview, LPN #41 indicated she was not aware the CNAs were not allowed to turn the oxygen on for a resident.</p> <p>On 2/16/11 at 9:25 a.m. during an interview, CNA #19 indicated she did not</p>				<p>1. Resident # 54, #51, and #109 had their flow rate adjusted at the time of survey. They were assessed and no negative outcomes were noted.2. Current residents with oxygen were assessed and no negative outcomes were noted.3. Clinical staff will be in serviced on the correct administration of oxygen and flow rates. Licensed staff will monitor flow rates during their clinical rounding daily.4. The DHS/designee will monitor flow rates through direct observation at least daily until 100% compliance is achieved, then at least weekly on an indefinite basis. Results will be reviewed at QA monthly for six months and then at least quarterly.5. 3/23/11</p>		03/23/2011

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	<p>think she was to fill or turn a resident's oxygen on, but the nurse had told her she could do it today.</p> <p>On 2/21/11 at 2:25 p.m. during an interview, the ADON indicated Resident #51's oxygen flow rate should be clarified with parameters related to her oxygen saturation.</p> <p>Resident #51's record was reviewed on 2/17/11 at 9:55 a.m. The resident's diagnoses included, but were not limited to, diabetes, anemia, hypertension, and congestive heart failure.</p> <p>The physician order, dated 1/26/11, was oxygen to maintain oxygen saturation greater than 92% (note % and liter flow per nasal cannula every shift).</p> <p>3.1-47(a)(6)</p>						

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F0329 SS=D	<p>Based on record review and interview, the facility failed to ensure psychotropic medications were not initiated without adequate behavioral indications for 1 of 3 residents reviewed for psychotropic medications in a sample of 17 (Resident # 109) and failed to ensure medications requiring blood pressure and pulse monitoring were monitored for 2 of 2 residents reviewed for blood pressure and pulse monitoring in a sample of 17. (Resident # 11 and # 54)</p> <p>Findings include:</p> <p>1. The record for Resident # 109 was reviewed on 2/15/11 at 3:40 p.m.</p> <p>Current diagnoses included, but were not limited to, senile dementia Alzheimer's type with delusions.</p> <p>A 10/6/10 physician order indicated an order for Risperdal 0.25 milligrams (antipsychotic medication) twice daily for delusions.</p> <p>The record, including the nursing notes, lacked any documentation of behaviors or delusions prior to initiation of the Risperdal.</p> <p>On 2/18/11 at 11 a.m., additional</p>			F0329	<p>1. Resident #17, #11, and #54 have had their drugs reviewed with their physician and appropriate orders received. The residents were assessed and no negative outcomes noted.2. Current residents with psychoactive drugs and parameters will have their therapeutic regime reviewed with their physician and appropriate orders implemented.3. The licensed staff will be in serviced on the requirements for the use of psychoactive drugs and the appropriate use of parameters with antihypertensive agents. Psychoactive drugs will be reviewed by the CAR team weekly for appropriate use and supporting behaviors.4. The DHS/designee will review psychoactive drugs at least weekly at CAR for appropriate use as part of the ongoing QA process. Antihypertensive agents will be reviewed with monthly rewrites for the appropriate use of parameters on an ongoing basis. Monitoring of this plan will continue indefinitely. Results will be reviewed monthly at QA for six months and then quarterly.5. 3/23/11</p>		03/23/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155678		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/21/2011	
NAME OF PROVIDER OR SUPPLIER  WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN46901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>information was requested from the Director of Nursing regarding the initiation of the Risperdal. At that time, she indicated, the nurse practitioner had ordered the medication for delusions.</p> <p>On 2/21/11 at 10:20 a.m., the Director of Nursing indicated she was unable to locate any additional information as to why the Risperdal was initiated for the resident.</p> <p>2. The record for Resident # 11 was reviewed 2/15/11 at 1:25 p.m.</p> <p>Current diagnoses included, but were not limited to, hypertension.</p> <p>A physician order dated 1/24/11 indicated an order to hold Toprol (medication for hypertension) if the resident's blood pressure was less than 100/50. The January and February 2011 Medication Administration Record (MAR) lacked blood pressure results for the administration of the Toprol on January 25, 27, 28, February 1, 2, 4, 5, 6, and 15.</p> <p>On 2/1/7/11 at 4 p.m., additional information was requested from the Director of Nursing regarding the blood pressure results.</p>						

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	<p>On 2/19/11 at 11 a.m., the Director of Nursing indicated she had not additional information to provide regarding the above blood pressure results.</p> <p>3. The record for Resident # 54 was reviewed on 2/15/11 at 2 p.m.</p> <p>Current diagnoses included, but were not limited to, hypertension.</p> <p>Current physician orders for February 2011 indicated an order for Metoprolol 25 milligrams twice daily and to hold the medication for a blood pressure of systolic blood pressure less than 90 and diastolic blood pressure less than 40 or a pulse less than 55.</p> <p>The MAR for February 2011 lacked blood pressure results upon rising on 2/1, 3, 6, 9 and at bedtime on 2/9/11. The Mar lacked pulse results for the upon rising dose and the bedtime dose of the medication for all days between 2/1-2-15/11.</p> <p>On 2/1/7/11 at 4 p.m., additional information was requested from the Director of Nursing regarding the blood pressure and pulse results.</p> <p>On 2/19/11 at 11 a.m., the Director of Nursing indicated she had no additional</p>						

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F0363 SS=E	<p>information to provide regarding the above blood pressure and pulse results.</p> <p>3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(b)(1)</p> <p>Based on observation, interview and record review, the facility failed to ensure menus were followed for residents who resided on the skilled Legacy-Dementia Unit. This deficient practice impacted 6 of 12 residents reviewed for following menus in a sample of 17 (Residents #65, #4, #63, #20, #83 and #104). Nine of 9 residents, who ate meals which were prepared in</p>			F0363	<p>1. The menus for residents identified in the survey were reviewed and assessed for appropriateness. The Cook was coached and counseled regarding the procurement of items as needed from the main kitchen inventory and the importance of following the menu spreadsheet. 2. Resident menus will be reviewed for accuracy and resident preferences will be appropriately care planned. 3. All dietary staff will be inserviced on the "Reading the Menu, Spreadsheet, and Tray Card" policy. The Director of Food Services (DFS) or designee will compare food served to the spreadsheet, menu, and tray card on at least 25 resident meals per week among the morning, noon, and evening meal times and will continue this monitoring indefinitely. 4. The results of the Menu Spreadsheet audit will be reviewed at QA monthly for six months and then quarterly. 5. 3/23/11</p>		03/23/2011

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	<p>the Legacy Kitchen, had the potential to be impacted by this deficient practice.</p> <p>Findings include:</p> <p>1.) Review of a current, 2009, facility policy titled "READING THE MENU AND SPREADSHEET", which was provided by the Food Services Supervisor on 2/18/11 at 9:20 a.m., indicated the following:</p> <p>"...it is necessary to read and follow the menu as</p>						

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	<p>written. Deterring from the menu may result in nutritionally inadequate meals, a modified diet receiving inappropriate items...."</p> <p>Review of the 2/16/11 breakfast menu, which was provided by the Food Services Supervisor on 2/15/11 at 12:12 p.m., indicated residents with regular diets were menued to receive:</p> <p>choice of cereal choice of eggs 4 bacon slices</p>						

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	<p>1 slice of wheat toast 6 ounces of a juice of choice 8 ounces of milk coffee/tea if desired</p> <p>2.) Resident #65's record was reviewed on 2/15/11 at 11:51 a.m.</p> <p>Resident #65's current diagnoses included, but were not limited to, dementia and non-insulin dependent diabetic. Resident #65 resided on a secured dementia unit.</p> <p>Resident #65 had a</p>						

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	<p>current 2/11 physician's order for a regular diet.</p> <p>3.) During a 2/16/11, 8:28 a.m. breakfast meal observation, Resident #65 was served 2 glasses of water, 1 piece of toast and 2 strips of bacon. Resident #65 was not served an egg nor an alternative protein as a replacement for the eggs. Resident #65 ate her bacon very quickly, then her toast. It took her 2 minutes to eat all the food served to her. She then took her finger and wiped the crumbs from</p>						

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	her plate and licked the crumbs from her finger.  4.) During a 2/16/11, 8:38 a.m., interview, cook #35 indicated she did not serve Resident #65 eggs, because the resident did not like eggs. She additionally indicated she never served Resident #65 eggs or a replacement for eggs because, "I can't get much out of her when I ask her what she wants."  5.) Review of a current, 2/18/11, facility document titled,						

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	<p>"Resident Service Location Report", which was provided by the Food Service Supervisor on 2/18/11 at 10:30 a.m., indicated 9 skilled residents received meals which were prepared in the Legacy kitchen.</p> <p>6.) Resident #4's record was reviewed on 2/18/11 at 9:15 a.m.</p> <p>Resident #4's current diagnoses included, but were not limited to, dementia and hypertension. Resident</p>						

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	<p>#4 resided on a secured dementia unit.</p> <p>Resident #4 had a current, 2/11, physician's order for a mechanical soft, honey thicken liquid, finger foods diet.</p> <p>7.) Resident #63's record was reviewed on 2/18/11 at 10:00 a.m.</p> <p>Resident #63's current diagnoses, included, but were not limited to, dementia, depression and anxiety. Resident #63 resided on a secured dementia unit.</p>						

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	<p>Resident #63 had a current, 2/11, physician's order for a regular diet with ground meat.</p> <p>8.) Resident #20's record was review on 2/18/11 at 9:30 a.m.</p> <p>Resident #20's current diagnoses include, but were no limited to, dementia and anxiety. Resident #20 resided on a secured dementia unit.</p> <p>Resident #20 had a current ,2/11, physician's order for a regular diet.</p>						

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	<p>9.) Resident #83's record was reviewed on 2/18/11 at 10:15 a.m.</p> <p>Resident #83's current diagnoses, included, but were not limited to, organic mental syndrome, diabetes and depression. Resident #83 resided on a secured dementia unit.</p> <p>Resident #83 had current 2/11, physician's orders for a mechanical soft diet with nectar thickened liquids.</p>						

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	<p>10.) Resident #104's record was reviewed on 2/15/11 at 11:50 a.m.</p> <p>Resident #104's current diagnoses included, but were not limited to, dementia, anorexia, and depression. Resident #104 resided on a secured dementia unit.</p> <p>Resident #104 had a current, 2/11, physician's order for a regular finger food diet.</p> <p>11.) A review of the 2/15/11, lunch menu,</p>						

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	<p>which was provided by the Food Services Supervisor on 2/15/11 at 12:12 p.m., indicated the following:</p> <p>all diet types, with the exception of pureed, where menued to receive bread in some form, either as a roast beef sandwich (2 slices) for finger food's diets or as a "Roast Beef Manhattan" (1 slice) for regular, no added salt, carbohydrate controlled and mechanical soft diets.</p> <p>12.) During a 2/15/11,</p>						

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	<p>12:15 p.m. to 12:40 p.m., observation of meal service on the Legacy Unit-skilled nursing Alzheimer's and dementia unit, no residents were observed receiving bread for lunch. Observations Residents #4 ,#63, #20, #83, #104 were not served bread or a bread replacement.</p> <p>13.) During a 2/15/11, 12:46 p.m., interview, Cook #35 indicated she had prepared the meal trays which were served in the Legacy skilled</p>						

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	<p>Alzheimer's, dementia secured unit. She indicated she had ran out of bread and had served no bread to the Legacy skilled unit. She had not served a bread alternate, such as a bun or crackers, She had not called the main kitchen to request additional bread and she had not notified her supervisor regarding the bread shortage. She indicated she did not know what to do if she ran out of a food item.</p> <p>3.1-20(i)(1)</p>						

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F0365 SS=D	<p>Based on observation, interview and record review, the facility failed to ensure residents who had physician's orders for finger foods were served finger food diets for 2 of 2 residents reviewed for finger food diets in a sample of 17 (Resident #4 &amp; #104).</p> <p>Findings include:</p> <p>1.) Review of a current, 2009, facility policy titled "READING THE MENU AND</p>			F0365	<p>1. The menus for residents identified in the survey were reviewed and assessed for appropriateness and accuracy.2. Resident menus will be reviewed for accuracy and resident preferences will be appropriately care planned.3. All dietary staff will be inserviced on the "Reading the Menu, Spreadsheet, and Tray Card" policy. The Director of Food Services (DFS) or designee will compare food served to the spreadsheet, menu, and tray card on at least 25 resident meals per week among the morning, noon, and evening meal times and will continue this monitoring indefinitely.4. The results of the Menu Spreadsheet audit will be reviewed at QA monthly for six months and then quarterly. 5. 3/23/11</p>		03/23/2011

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	<p>SPREADSHEET", which was provided by the Food Services Supervisor on 2/18/11 at 9:20 a.m., indicated the following:</p> <p>"...it is necessary to read and follow the menu as written. Deterring from the menu may result in nutritionally inadequate meals, a modified diet receiving inappropriate items...."</p> <p>A review of the 2/15/11, lunch menu, which was provided by the Food Services Supervisor on</p>						

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	<p>2/15/11 at 12:12 p.m., indicated "Finger Food Diets" were menued to receive the following:</p> <p>1 ground cold roast beef sandwich 1 hashbrown patty 4 ounces of green beans 4 ounces of cherries.</p> <p>A review of of the 2/15/11, supper menu, which was provided by the Food Services Supervisor on 2/17/11 at 4:00 p.m., indicated "Finger Food Diets" were menued to receive the following:</p>						

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	<p>4 ounces of cut-up catfish 2 hushpuppies a wedge of iceberg lettuce 4 ounces of fresh fruit.</p> <p>2.) Resident #4's record was reviewed on 2/18/11 at 9:15 a.m.</p> <p>Resident #4's current diagnoses included, but were not limited to, dementia and hypertension. Resident #4 resided on a secured dementia unit.</p>						

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	<p>Resident #4 had a current, 2/11, physician's order for a mechanical soft, honey thicken liquid, finger foods diet.</p> <p>Resident #4 had a 4/14/10 clinically at risk note which indicated she would be served finger foods, when a mechanical soft diet would permit, in order to encourage the resident to pick up the food with her hands and eat. The decision was made due to the resident attempting to pick up food items.</p>						

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	<p>During a 2/15/11, 12:15 p.m. to 12:40 p.m., observation of meal service Resident #4 was served ground roast beef, mashed potatoes and gravy, greens and cherry pie.</p> <p>Resident #4 was not served bread a cold ground roast beef sandwich, green bean or cherries.</p> <p>Resident #4 ate less than 30% of her meal.</p> <p>During a 2/15/11, 4:45</p>						

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	<p>p.m. to 5:15 p.m., observation of supper meal service, Resident #4 was served ground chicken, cooked cabbage, hushpuppies and apple sauce. The only items served which she could pick-up with her fingers were hushpuppies.</p> <p>Resident #4 at less than 30% of her meal.</p> <p>4.) Resident #104's record was reviewed on 2/15/11 at 11:50 a.m.</p> <p>Resident #104's current</p>						

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	<p>diagnoses included, but were not limited to, dementia, anorexia, and depression. Resident #104 resided on a secured dementia unit.</p> <p>Resident #104 had a current, 2/11, physician's order for a regular finger food diet.</p> <p>During a 2/21/11, 1:35 p.m. interview, the Director of Nursing indicated Resident #104 had a finger food diet order in hopes he would pick up food and self feed, even while moving</p>						

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	<p>about, in order to increase consumption.</p> <p>During a 2/15/11, 12:15 p.m. to 12:40 p.m., observation of meal service Resident #104 was served roast beef, mashed potatoes and gravy, greens and cherry pie. Resident #104 was not served bread.</p> <p>During a 2/15/11, 12:15 p.m. to 12:40 p.m., observation of meal service, Resident #104 showed no interest in his roast beef, mashed potatoes and gravy and</p>						

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	<p>greens. Resident #104 got up from the table multiple times and walked around. Staff members tried to redirect him to his roast beef without success.</p> <p>Resident #104 did not have any item on his tray that he could eat with his fingers or carry as he moved about the unit.</p> <p>Resident #104 at less than 25% of his meal.</p> <p>3.1-21(a)(3)</p>						

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F0371 SS=E	<p>Based on observations, record review, and interviews, the facility failed to ensure a clean and sanitary environment related to equipment, floors, handwashing and glove use, and hair covering for 3 of 3 kitchen areas observed during 4 of 5 days of observation. (February 15, 16, 17, and 18, 2011) This had the potential to affect 60 of 82 residents who dined in the facility's dining rooms (Main dining room, Transitional Care Suites, and Legacy).</p> <p>Findings include:</p> <p>1. The Director of Food Services (DFS) provided the following policies on 2/15/11 at 10:25 a.m. These policies were as follows:</p> <p>"TITLE: HAND WASHING</p> <p>POLICY: Employees will use proper hand washing techniques to prevent the spread of infection.</p> <p>PROCEDURE:</p> <p>1. All hands are washed:</p> <p>A. When entering the Nutrition Services Department.</p> <p>B. Before starting work in the Nutrition</p>			F0371	<p>1. All kitchen areas identified in the survey related to equipment and floors were cleaned. Dietary staff were instructed to wear appropriate hair netting including beard restraint. Dietary staff were instructed on the proper handwashing technique.2. Dietary staff will be inserviced on the "Hand Washing" policy, "Food Safety" policy, and the "Dress Code and Personal Hygiene" policy. Dietary staff will also be inserviced on proper procedures for kitchen cleanliness to include the removal of refuse, floor cleaning, equipment cleaning, table cleaning, and proper cleaning and maintenance of food storage areas.3. Dietary staff checklists and cleaning schedules have been revised and updated to include areas identified in the survey. The Director of Food Services (DFS) or designee will review the revised checklists and schedules at least five times weekly. The DFS or designee will perform a sanitation audit of each kitchen area at least one time weekly. The Consultant Dietician or Regional Dietary Support person will perform at least one independent sanitation audit monthly. These weekly and monthly review will continue indefinitely.4. The results of the checklist and schedules audit, the internal sanitation audits, and consultant audits will be reviewed</p>		03/23/2011

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	<p>Services Department.</p> <p>...2. Hand washing procedure:</p> <p>...B. Add soap and rub well, especially between fingers and around and underneath fingernails for a minimum of 20 seconds.</p> <p>...D. Wipe dry with disposable paper towels.</p> <p>E. Turn off water faucet with paper towel.</p> <p>The "CHECKS &amp; BALANCE REPORT" indicated the following:</p> <p>AM (morning) and PM (evening )Cook, Prep Cook Aide, and TCS (Transition Care Suites) Aide tasks included, but were not limited to, wrap, label and date all food products before returning to storage.</p> <p>The AM and PM TCS was to check the sink to ensure that is it is free of dishes, food, and debris.</p> <p>The "Dishwasher's Weekly Cleaning Schedule" indicated the dishwasher was to "Sweep &amp; Mop Everywhere" every day of the week.</p>				<p>at QA monthly for six months and then quarterly.5. 3/23/11</p>		

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	<p>The DFS provided the following policies on 2/17/11 at 4:00 p.m. These policies indicated the following:</p> <p>"Title: Inservice: Food Safety</p> <p>...2. Provide the following information</p> <p>A. Introduction: Keeping foods safe is critical to preventing illness carried to people by food (referred to as foodborne illness). Those who are elderly and/or sick are at a higher risk for complications and death from foodborne illness than healthy people...The three main causes of foodborne illness are...and poor personal hygiene....</p> <p>...c. Practice good personal hygiene -</p> <p>1. Wash hands for 20 seconds with soap and water...</p> <p>2. Use plastic gloves anytime you touch food directly and change gloves every time a contaminated surface is touched. Wash hands between changing gloves.</p> <p>3. Cover hair completely with hair restraints....."</p> <p>"Title: Dress Code and Personal Hygiene</p>						

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	<p>...2. The organization has strict requirements regarding hair:</p> <p>* Employees will wear hairnets that COMPLETELY covers the hair while in the kitchen or serving food</p> <p>* There are no authorized substitutes for the required hair covering</p> <p>* Beard and mustache must be covered with effective hair restraint</p> <p>3. All employees are required to wash their hands on these occasions:</p> <p>...* after disposing of or handling trash or food</p> <p>...* After picking up anything from the floor</p> <p>* Before and after serving food to residents and patients...."</p> <p>"Title: Food Temperatures - Serving Line</p> <p>...PROCEDURE:</p> <p>...5. Proper procedures are used so that measured temperatures are accurate and contamination is prevented:</p>						

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	<p>...B. Thermometers are clean, rinsed, and sanitized before, after, and in between use. An alcohol swab may be used to sanitize the thermometer between uses at one meal....."</p> <p>2. On 2/15/11 from 9:55 a.m. to 10:30 a.m., the initial tour was conducted in the main kitchen with the Director of Food Services (DFS). The following was observed:</p> <p>As the tour was started, Maintenance staff member #1 was observed to enter the kitchen with a large ladder, walk through the kitchen to the 3 compartment sink, set up his ladder, and climbed up this ladder to a ceiling panel, which was opened as he looked into it. No hair net was applied during this observation.</p> <p>At the vegetable preparation area, and opened trash barrel was observed 3/4ths full of vegetables debris and paper debris with no lid visible. No one was working in the area at this time.</p> <p>The meat cutter was observed with a small area of dried yellow substance and another area of dried pink substance on the surface of the meat cutter. At this same time during an interview, the DFS indicated the meat cutter was used last</p>						

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	<p>night and needed to be cleaned again</p> <p>The freezer was observed with paper debris and food crumbs scattered on the floor. On the ceiling above 1 of the 2 fans in the back of the freezer, a build up of ice droplets were observed on the ceiling. Two boxes of frozen cookie dough and 1 box of dough for rolls were observed higher than 18 inches from the ceiling. At this same time during an interview, the DFS indicated 18 inches should be left between the ceiling and shelves to allow for air circulation in the freezer.</p> <p>In the kitchen, the oven was observed with 2 different 3 inch areas of grease-like, brown to black accumulated substance below the oven door and lower panel. At this same time during an interview, the DFS indicated the oven was cleaned about 2 weeks ago.</p> <p>The bottom shelf of the metal table where the steamer was located was observed with food crumbs scattered around the box of paper tissue.</p> <p>The front deep fryer was observed with spilled dry white areas and grease-like areas on the front of the fryer.</p> <p>In the dry storage area, the floor was</p>						

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	<p>observed with scattered debris of loose papers and crumbs. A peanut butter jar was observed on the shelf with a broken lid. Also, a scoop was observed inside the sugar bin with its handle down into the sugar. The flour bin also had a scoop inside with the handle of the scoop covered with flour. At this same time the DFS indicated the peanut butter should be thrown away, which was done now, and the sugar and flour scoops should not be stored in the bins. He also indicated the floors were swept and mopped daily and deep cleaned 1 time every week.</p> <p>The large mixer next to the 3 compartment sink was observed with a pink substance and dried dough on the outer surface above the beater's connection.</p> <p>The ice machine's front filter was observed with a thin layer of accumulated gray dust on the top of the filter's grill cover. At this same time during an interview, the DFS indicated the filter should be cleaned 2 times a month as marked on the outside of the ice machine.</p> <p>Above the serving area, a area of painted seam in the ceiling was observed loosely hanging leaving an open gap.</p>						

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	<p>In the supply storage area, a layer of dust was observed under the shelf next to the outside wall.</p> <p>In the TCS (Transitional Care Suites) kitchen, the following was observed:</p> <p>The DFS indicated the sink next to the refrigerator and drink dispenser was the designated handwashing sink.</p> <p>In the freezer, a resident's opened container of ice cream was undated.</p> <p>In the ice cooler, a scoop was stored inside the ice of the half filled cooler. At this same time during an interview, the DFS indicated the scoop for the ice was to be stored out of the cooler.</p> <p>In the nourishment room in the hallway, upon entering the room 2 quarter sized orange colored, dry areas were observed on the ceiling.</p> <p>3. On 2/15/11 at 11:30 a.m. in the kitchen as the DFS took food temperatures, he was observed to complete the beef gravy temperature. With the food thermometer, the DFS was observed to dip and swish the food thermometer in the washing sink of the 3 compartment sink, then, into the rinse sink, and lastly, in the sanitizer sink.</p>						

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	<p>As he returned to the serving table, the DFS was observed to shake the thermometer before he checked the mashed potatoes's food temperature. No drying of the food thermometer was observed.</p> <p>Next, after the DFS was observed to complete his food temperatures, he disposed of the trash in the black trash can where the lid was observed covered with a sticky to dry clear substance.</p> <p>During this same observation, dietary staff #2 was observed in the kitchen washing dishes at the 3 compartment sink with no hair covering over his beard.</p> <p>4. On 2/15/11 at 11:28 a.m. in the Legacy kitchen, 1 of the 2 designated handwashing sinks was observed blocked by a food cart containing soiled dishes.</p> <p>In the refrigerator, a 1/2 filled package of lettuce was undated, and an egg was broken in the egg crate. At this same time, the DFS instructed the dietary staff member to throw the cracked egg away.</p> <p>In the freezer, an opened container of ice cream for a resident was undated.</p> <p>The black trash can lid was observed with a dried clear sticky substance on it.</p>						

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NAME OF PROVIDER OR SUPPLIER  WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN46901			
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	<p>As the DFS prepared to take food temperatures, he dropped his thermometer on the floor. He was then observed to swish the food thermometer in the wash sink, then, the rinse sink, and lastly, the sanitizer sink of the 3 compartment sink and shake it to dry. He was then observed to take the food temperature of the beef serving with this same thermometer with no further cleansing of the food thermometer observed.</p> <p>Two trays with individual servings of cherry pie were observed on a food cart with no coverings over the pies.</p> <p>As Dietary staff #3 was observed to scrape/stir a bowl of food in preparation, the spatula used was observed with 1/3rd of the top of the spatula broken off.</p> <p>The bottom shelves of the 2 metal tables in the middle of the kitchen were observed with loose food crumbs mainly in the corners of the tables with scattered water spots.</p> <p>Three of three ceiling vents located around the serving/preparation areas of the kitchen were observed with a layer of light to darker gray accumulated loose dirt on the grills of the ceiling vents. The</p>						

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	<p>ceiling vent above the preparation area and by 1 of the handwashing sink was observed with darker gray accumulated dust also on the ceiling around the vent.</p> <p>5. On 2/15/11 at 11:55 a.m. in the main kitchen as lunch was being prepared and delivered, the Delivery man #4 was observed walking through the kitchen as he was delivering milk. He was observed with no hair covering on as the DFS indicated to him he needed to be wearing a hair net. As Dietary staff #2 entered the kitchen, no covering was observed over his beard as he began to assist with lunch preparation/serving. Also, Dietary staff #5 was observed to have no covering over his beard as he proceeded to leave the kitchen taking a food cart out of the kitchen for delivery.</p> <p>6. On 2/15/11 from 12:05 p.m. to 1:05 p.m., the following was observed in the TCS unit's kitchen:</p> <p>Dietary staff #5 with an uncovered beard and gloved hands was observed to retrieve food from the refrigerator as he was preparing to serve the residents' lunch.</p> <p>The designated handwashing sink was observed with a metal plate cover in the sink. This double sink also was observed</p>						

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	<p>with tongs and a food tray on the other side. This food tray covered the sink opening.</p> <p>An unidentified CNA holding a cup of ice was observed to enter the kitchen without a hair net on. After she obtained a glass of water from the handwashing sink, she left the kitchen.</p> <p>Dietary staff #5 was observed to leave the kitchen wearing his same gloves. When Dietary staff #5 returned to the kitchen with no beard covering on and no gloves on, he was observed to handwash for 15 seconds, turned the water off with his wet hand, and then, finished drying his hands. After donning a new pair of gloves, he was observed to cut the bread in half for the beef manhattan.</p> <p>Dietary staff #6 was observed to take a drink out of the kitchen into the dining room, returned to the kitchen and checked the paper menus, and assisted preparing the food trays placing her thumb inside the plate cover for 2 tray preparations observed.</p> <p>Dietary staff #6 was again observed to leave the kitchen to get an additional salad. When she returned, she continued to serve a drink and covered the</p>						

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	<p>individual pies. No handwashing/handgel was observed. As the last of the meals were being served, Dietary staff #6 was again observed to put her thumb inside the metal plate covers as she served them.</p> <p>After Dietary server #7 was observed with no hair net and to handwash for 10 seconds, she was observed to obtain individual servings of the pie and proceeded to serve them in the dining room.</p> <p>Dietary server #8 was observed to clean up a piece of pie off of the floor in the dining room with paper towels. She was observed to enter the kitchen without a hair net and handwash for less than 10 seconds, turned the water off with her wet hands, and then, dried her hands. She then returned to the dining room and continue to help the residents in the dining room.</p> <p>7. On 2/15/11 at 4:25 p.m. in the TCS unit, the serving for dinner was observed. CNA #15 was observed at the serving counter of the kitchen with no hair net on. She was mixing up Resident #51's thickened liquids. Dietary staff #17 was observed to handwash for 15 seconds as she continue to prepare to serve the dinner. CNA #15 was observed to return</p>						

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	<p>to the kitchen and obtained a glass of water from the sink and a glass of orange juice. No handwashing or hair net was observed used by CNA #15.</p> <p>On 2/15/11 from 5:23 p.m. to 5:55 p.m. in the TCS unit, the serving for dinner was again observed. CNA #15 and CNA #16 were both observed in the food serving area of the kitchen 2 times with no hair nets on. The DFS was observed to enter the kitchen and assist with drinks and cut up a piece of fish for a mechanical soft diet. No handwashing was observed. Next, Dietary staff #17 with gloved hands was observed to remove 2 hot dogs from the microwave, place a hamburger patty in the microwave, touched the hot dogs with her gloved finger to check for temperature, removed the hot dog buns from the package, and put them in the buns. Next, she removed the hamburger from the microwave and with the same gloved hands placed lettuce on the hamburger, which was served to a resident in the dining room.</p> <p>Trays were observed in the designated handwashing sink.</p> <p>As DFS entered the kitchen, he instructed Dietary staff #17 to remove the trays from the handwashing sink. After they were</p>						

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	<p>removed, the DFS was observed to handwash for 10 seconds.</p> <p>8. On 2/16/11 at 9:40 a.m. in the TCS dining room, an unidentified dietary staff was observed for 3 different tables to place the clean tablecloths onto the tables by fanning them out over the tables.</p> <p>9. On 2/17/11 from 8:00 a.m. to 8:30 a.m., the following was observed in the TCS kitchen:</p> <p>A tray was observed in the designated handwashing sink.</p> <p>CNA #19 was observed in the kitchen serving area without a hair net on.</p> <p>CNA #42 without a hair net on was observed in the kitchen serving area covering a food tray up.</p> <p>Dietary staff #43 was observed to drop and pick up a cocoa pack mix from the floor at the drink counter outside the kitchen area. With the same gloved hands, Dietary staff #43 was observed to continue to go in and out of the kitchen serving area obtaining drinks and serving breakfast.</p> <p>10. On 2/17/11 at 9:15 a.m., CNA #19</p>						

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	<p>without a hair net on was observed to go into the TCS kitchen serving area to check on the cereal available in the cabinets for a resident still in the dining room.</p> <p>11. On 2/17/11 at 2:05 p.m., the following was observed in the kitchen:</p> <p>Dietary staff #9 was observed to handwash, turned the water off with her wet hands, and then, dried her hands. She then picked up a dropped paper towel and proceeded to the preparation area. She rewashed her hands when instructed by the DFS. At this same time during an interview, the DFS indicated no hair net was required if staff was going from the entry way straight to the refrigerator, but one should be worn in the TCS kitchen serving area.</p> <p>Dietary staff #10 was observed in the kitchen with his beard uncovered.</p> <p>At the vegetable preparation area with no one working, the trash barrel was opened with no lid visible and contained vegetable and paper debris.</p> <p>Throughout this main kitchen the floor, oven/stove door, floor, and metal tables/shelves were observed with the loose paper and food debris as before. At</p>						

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	<p>this same time during an interview, the DFS indicated he understood the kitchen's physical condition concerning the "visible dirt."</p> <p>In the freezer, the accumulation of ice droplets were again observed in front of the fan with a 2 inch ice buildup observed on the black pipe below the fans. The DFS indicated he would have maintenance look at the freezer.</p> <p>In the refrigerator, 6 salad plates on a food cart were observed uncovered until covered presently by the DFS.</p> <p>The dishwasher was observed with an accumulation of brown to dark brown substance along the top metal seam of the dishwasher with loose brown food-like crumbs covering the top of the dishwasher.</p> <p>An uncovered barrel of overflowing soiled napkins and tablecloths was observed brought into the middle of the kitchen. One napkin was observed to fall out of the barrel onto the floor before it was taken out of the kitchen.</p> <p>The large mixer was observed with a dried white substance above the area where the beaters were placed. The DFS</p>						

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	<p>indicated they had used the mixer to mix cream cheese icing last night and the mixer needed to be cleaned again before use.</p> <p>The dry storage room was again observed with a layer of dust under the shelf on the outside wall with dried black and dried spilled areas scattered throughout the room. The DFS indicated the room had "obviously" not been swept/cleaned for a few days.</p> <p>Dietary staff #11 was observed walking through the kitchen to the dry storage area without a hair net on.</p> <p>12. On 2/18/11 at 8:30 a.m. in the Legacy kitchen, the front of the dishwasher was observed with an accumulation of a brown substance along the separation between the dishwasher door and lower panel.</p> <p>13. On 2/21/11 at 3:43 p.m. during an interview, the DFS indicated the freezer did have a leak and was to be fixed.</p> <p>3.1-21(i)(3)</p>						

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F0372 SS=E	<p>Based on observations and record review, the facility failed to ensure the overflowing kitchen's trash was emptied timely for 2 of 3 kitchens observed. (Main kitchen and the Transitional Care Suites)</p> <p>Findings include:</p> <p>1. The Director of Food Services (DFS) provided the "CHECKS &amp; BALANCE REPORT" policy on 2/15/11 at 10:25 a.m. This current policy indicated the AM Prep Cook Aide was to take out the lunch trash, and the PM Prep Cook Aide was to take out the evening trash.</p> <p>On 2/15/11 at 5:23 p.m. in the TCS unit, the serving for dinner was observed. The trash container by the handwashing sink was stacked on top with boxes, paper debris, gloves, and food debris. During this dinner observation, Dietary staff #17 was observed to add more paper debris and gloves to the stack on top of the trash container.</p> <p>On 2/17/11 at 2:05 p.m. upon entering the main kitchen, the black trash container by the stove/oven area was observed overflowing with food and paper debris. At this same time during an interview, the DFS indicated the trash needed to be</p>			F0372	<p>1. All kitchen trash receptacles identified in the survey were removed and refuse disposed of appropriately.2. Dietary staff will be inserviced on the "Food Safety" policy which will include the proper procedure and removal of refuse from the kitchen areas.3. Dietary staff checklists and cleaning schedules have been revised and updated to include refuse removal schedules. The Director of Food Services (DFS) or designee will review the revised checklists and schedules for appropriate trash removal at least five times weekly. The DFS or designee will perform a sanitation audit of each kitchen area at least one time weekly. The Consultant Dietician or Regional Dietary Support person will perform at least one independent sanitation audit monthly. These monthly and weekly audits will continue indefinitely.4. The results of the trash removal checklist and schedules audit will be reviewed monthly at QA for six months and then quarterly.5. 3/23/11</p>		03/23/2011

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F0425 SS=D	<p>emptied and instructed a dietary staff member to empty the trash.</p> <p>3.1-21(i)(5)</p> <p>Based on record review and interview, the facility failed to ensure physician ordered medications were available for administration for 1 of 15 resident's reviewed for medication availability in a sample of 17. (Resident # 93)</p> <p>Findings include:</p> <p>1. A 2/1/10 policy titled "Medication ordering and receiving from pharmacy" was provided by the Administrator on 2/21/11 at 8 a.m. and deemed as current. The policy indicated: "Policy: Medications and related products are received from the dispensing pharmacy on a timely basis...If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt...."</p> <p>2. The record for Resident # 93 was reviewed on 2/17/11 at 9:30 a.m.</p> <p>A physician order dated 9/16/10 indicated an order to Vitamin C 500 milligrams to be given twice daily.</p>		F0425	<p>1. The medication for resident #93 had been delivered at the time of survey. The resident was assessed with no negative outcomes from the alleged deficient practice.2. Current residents MAR's and TAR's have been reviewed for medication circled as unavailable and appropriate follow up and assessments completed.3. The licensed staff will be inserviced on the procedure for the back up pharmacy and physician notification of medication delays for alternate medication that is available in the Pyxis. The DHS/designee will review the MAR's and TAR's at least 5 days per week for circled meds as unavailable and complete appropriate follow up.4. The DHS /designee will review the MAR's and TAR's 5 days per week until 100% compliance is achieved for 4 weeks then at least weekly as part of the ongoing QA process.5. 3/23/11</p>		03/23/2011	

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	<p>The Medication Administration Record (MAR) for September 2010 indicated the Vitamin C was not available between 9/17-9/20/10. The resident did not receive 7 doses.</p> <p>The MAR for October 2010 indicated the resident was to receive Benaprotein supplement three times daily. The MAR indicated the Benaprotein was unavailable between 10/9/10-10/13/10, missing 15 doses.</p> <p>On 2/21/11 at 9:30 a.m., the Director of Nursing indicated she was unsure why the Vitamin C and Benaprotein were not available.</p> <p>3.1-25(a)</p>						

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F0441 SS=E	<p>Based on observations, record review, and interviews, the facility failed to ensure infection control practices were followed in a manner to prevent the potential for the spread of infections and diseases concerning 3 of 5 observations of linen handling, for 5 of 8 equipment handling observations, for 4 of 6 observations of handwashing and glove use during personal care and medication pass. This deficiency affected 8 of 9 residents observed concerning infection control. (LPN #'s 13, 14, 44, 24, and 25; Assistant Director of Nursing; RN #'s 21; CNA #'s 19, 42, 12, 15, 22, 23) (Resident #'s 51, 36, 81, 20, 14, 109, 93, and 54)</p> <p>Findings include:</p> <p>1. The "Handwashing" policy was provided by the Administrator on 2/21/11 at 8:00 a.m. This current policy indicated the following:</p> <p>"Standard</p> <p>Handwashing is the single most important factor in preventing transmission of infections. Inadequate handwashing has been responsible for many outbreaks of infectious disease in LTCF (Long Term Care Facilities). Implementation of PROPER handwashing practices has interrupted outbreaks in many settings.</p> <p>Policy</p>		F0441	<p>1. Residents # 51, 36, 81, 20, 14, 93, 109, and 54 have been assessed with no negative outcomes from the alleged deficient practice. Staff involved have had one on one coaching on the alleged deficient practices observed. 2. Infection control logs will be reviewed for trends as to assignments and follow up with employees completed. 3. The clinical staff will be inserviced on infection control practices, in particular handwashing, linen handling, equipment handling, and clean procedure for treatments. 4. The DHS/designee will observe at least five staff among all three shifts providing care and treatments at least 3 days per week until 100% compliance is achieved for 4 weeks, then at least weekly for 6 months. The DHS/designee will review the infection control logs, track and trend for any patterns. The results will be reviewed with the QA committee monthly for six months and then at least quarterly. 5. 3/23/11</p>		03/23/2011	

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	<p>All health care workers shall wash their hands frequently and appropriately....</p> <p>Health Care Workers shall wash hands: ...3. Before/after having direct physical contact with residents. 4. After removing gloves...."</p> <p>The "Non-Sterile Gloving Technique" policy was provided by the Administrator on 2/21/11 at 8:00 a.m. This current policy indicated the following:</p> <p>"Objective: 1. To reduce the risk of transmission of infection between residents, from resident to HCW (Health Care Worker), from HCW to resident.</p> <p>...Procedure ...To Remove Gloves ...7. Take gloves with other waster from the room to regular waste container. 8. Wash hands."</p> <p>The "General Guidelines for Dressing Changes" policy was provided by the Administrator on 2/17/11 at 12:00 p.m. This current policy indicated the following:</p> <p>"PURPOSE: To ensure measures that will promote and maintain good skin integrity while maintaining standard measures that will minimize/control contamination.</p> <p>PROCEDURE: ...4. Open dressing pack. 5. Wash hands with soap and water. 6. Put on first pair of disposable gloves. 7. Remove soiled dressing and discard in plastic</p>						

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	<p>bag.</p> <p>8. Dispose of gloves in plastic bag.</p> <p>9. Wash hands with soap and water.</p> <p>...14. Remove gloves and discard with all unused supplies in plastic bag.</p> <p>15. Wash hands with soap and water....."</p> <p>The "GUIDELINES FOR HANDLING LINEN" policy was provided by the Nursing Consultant on 2/21/11 at 1:24 p.m. This current policy indicated the following:</p> <p>"PURPOSE: To provide clean, fresh linen to each resident. To prevent contamination of clean linen.</p> <p>PROCEDURE: Clean Linen ...4. Linens should be carried away from the body to prevent contamination from clothing....."</p> <p>The "Guidelines for Contact Precautions" policy was provided by the Nursing Consultant on 2/21/11 at 1:24 p.m. This current policy indicated the following:</p> <p>"Purpose: To provide guidelines to prevent the spread of infectious disease organisms.</p> <p>Procedures: ...f. A stethoscope, sphygmomanometer, thermometer, and scissors for care...If use of common equipment is unavoidable, then adequate cleaning and disinfecting is necessary before use with other residents....."</p> <p>2. On 2/15/11 from 12:40 p.m. to 1:35 p.m., Resident #36's personal care was observed. After care was completed, CNA #12 was observed to</p>						

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	<p>hold the pillow next to her uniform before placing it under the resident's legs. After the resident's positioning was completed, CNA #12 was observed to handwash for less than 10 seconds.</p> <p>3. On 2/15/11 from 1:47 p.m. to 2:10 p.m., Resident #51's dressing change was observed on the resident's right buttock. LPN #13 was observed to handwash for less than 10 seconds as she prepared her dressing supplies. At this same time during an interview, LPN #13 indicated the resident was incontinent of urine and removed her gloves and retrieved a new brief from the resident's closet. With new gloves LPN #13 removed the wet brief. After she was observed to handwash for 12 seconds, she donned a new pair of gloves. After LPN #13 was observed to complete the dressing change, she then tucked the soiled incontinent pad under the resident, removed her gloves and donned a new pair, and assisted the resident to turn to the other side. As she removed the incontinent pad, she indicated the resident had been incontinent of urine again and removed her gloves. After LPN #13 handwashed for 10 seconds, she donned a new pair of gloves, changed the resident's brief another time and repositioned her in the bed. She then removed her gloves, bagged her trash, donned another pair of gloves and bagged the soiled incontinent pad and left the room with the bags. No handwashing/handgel use was observed.</p> <p>4. On 2/15/11 at 4:10 p.m., Resident #36's transfer from the bed to her wheelchair was observed. LPN #14 was observed to enter the room and disconnected the resident's G-tube (gastrostomy tube) from the continuous feeding pump for the transfer. LPN #14 was then observed to handwash for 10 seconds before she left the room. Next, CNA #15 was observed to</p>						

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	<p>dress the resident. After the resident was transferred from her bed to the wheelchair, she was wheeled out of the room to the therapy room. No handwashing was observed as CNA #15 left the therapy room. Next, LPN #14 entered the therapy room with the G-tube continuous pump and was observed to check the G-tube by aspiration before reconnecting the G-tube to the continuous feeding pump. After LPN #14 rinsed the asepto out in the utility room, she returned it to the bag on the continuous pump, handwashed for less than 10 seconds, returned to the nurse's station, and answered a phone call.</p> <p>5. On 2/17/11 at 8:50 a.m. in preparation to transfer Resident #51 to her bed, CNA #42 was observed to fan out a folded full sheet over the resident's bed to position it on the bed.</p> <p>6. On 2/17/11 from 8:50 a.m. to 9:10 a.m., Resident #51's personal care was observed. After the resident was transferred to her bed by CNA #19 and CNA #42, the resident's pants were removed. As they turned the resident, the resident's treatment dressing on her buttocks was observed with no date on it as the brief was removed. CNA #19 and CNA #42 indicated the resident had been incontinent of urine with a small amount of loose bowel movement. CNA #42 indicated the resident was constantly incontinent of urine anytime the resident was moved. With gloved hands CNA #19 cleansed the resident's rectal area, removed her gloves and donned a new pair, and applied a protective cream to the resident's buttocks. No front peri-care was observed completed. CNA #19 continued to pull her pants up while turning her back and forth before she removed her gloves. CNA #19 controlled the Hoyer lift as the resident was transferred back to her wheelchair before</p>						

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	<p>handwashing was completed. At this same time during an interview, CNA #42 indicated they try to keep the resident dry especially in her abdominal folds and would use wipes to clean her unless it is "too bad" then they would use washcloths. Also, at this same time during an interview, CNA #19 indicated they try to keep her as dry as possible by checking her before and after she eats and before and after therapy. CNA #19 indicated handwashing was completed after care was done.</p> <p>7. On 2/17/11 at 11:20 a.m., CNA #19 was observed to undress Resident #51 in preparation for her dressing change. After LPN #44 entered to complete the dressing change, CNA #19 left the room with no handwashing/handgel use observed.</p>						

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F0441 SS=E	<p>8. During a medication pass observation of Resident #14 on 2/15/11 at 11:30 a.m., LPN # 21 carried the accucheck strip bottle into the resident's room and placed them on the over the bed table. When accucheck was completed, she picked up the bottle and placed it in a plastic bin in the medication cart with other accucheck supplies.</p> <p>9. During the initial tour on 2/15/11 at 9:50 a.m. with the Assistant Director of Nursing, Resident # 93 was in his wheel chair in his room. His anchored catheter tubing on the floor under his wheelchair. At that time during interview, the Assistant Director of Nursing indicated the tubing should not be on the floor. She adjusted the tubing, picked up her sheet of paper and pen and exited the room and continued tour without washing her hands.</p> <p>On 2/15/11 at 1:05 p.m., the resident was wheeling himself out of the dining room. His anchored catheter tubing was dragging the floor under his wheelchair. At that time, during interview, LPN # 24 indicated the tubing should not be on the floor. She adjusted the tubing. She then was given a brown bag of medications delivered from the pharmacy. She entered the Resident's room, laid the bag of</p>			F0441	<p>1. Residents # 51, 36, 81, 20, 14, 93, 109, and 54 have been assessed with no negative outcomes from the alleged deficient practice. Staff involved have had one on one coaching on the alleged deficient practices observed. 2. Infection control logs will be reviewed for trends as to assignments and follow up with employees completed. 3. The clinical staff will be inserviced on infection control practices, in particular handwashing, linen handling, equipment handling, and clean procedure for treatments. 4. The DHS/designee will observe at least five staff among all three shifts providing care and treatments at least 3 days per week until 100% compliance is achieved for 4 weeks, then at least weekly for 6 months. The DHS/designee will review the infection control logs, track and trend for any patterns. The results will be reviewed with the QA committee monthly for six months and then at least quarterly. 5. 3/23/11</p>		03/23/2011

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	<p>medications on chair in the resident's room.</p> <p>During a personal care observation of Resident # 93 on 2/15/11 at 1:35 p.m., CNA # 22 with ungloved hands removed the resident's anchored catheter bag from the dignity cover and gave it to CNA # 23 who without gloves placed the bag and tubing into the resident's lap. The CNAs then proceeded to transfer the resident by hooyer lift to his recliner. They adjusted the resident in the chair, give him his call light, elevates his feet, then they wash their hands.</p> <p>10. During a personal care observation of Resident # 109 on 2/15/11 at 1:45 p.m., CNA # 22 with ungloved hands, places the resident's anchored catheter bag and tubing onto the resident's chest. CNA # 22 and # 23 transferred the resident to the bed by hooyer lift. During the transfer the anchored catheter tubing and the resident's oxygen tubing were tangled together. After the resident was placed in bed, both CNAs' donned gloves without washing their hands and completed the resident's care.</p> <p>11. During a medication pass observation of Resident # 81 on 2/15/11 at 4:15 p.m., LPN # 20 checked the resident's</p>						

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F0456 SS=E	<p>gastrostomy tube placement then laid the stethoscope on the resident's bed. When she was completed with the medication pass, she picked up the stethoscope and placed it around her neck, draping on the front of her uniform.</p> <p>12. During a dressing change observation of Resident # 53 on 2/16/11 at 2:30 p.m., LPN # 25, during the dressing change, laid a roll of cover-all tape in the resident's bed. When she was completed, she picked up the tape and returned it to the treatment cart with other treatment items.</p> <p>3.1-18(l) 3.1-19(g)</p> <p>Based on observation and interview, the facility failed to ensure wheelchair arms were in good repair for 3 of 4 residents observed for wheelchair repair in a sample of 17 (Resident # 11, # 51, and # 36) and for 2 of 2 residents observed for wheelchair repair in a supplemental sample of 3. (Resident # 14 and # 1)</p> <p>Findings include:</p> <p>1. During a medication pass observation on 2/15/11 at 11:30 a.m., Resident #1 was in her wheelchair in her room. The vinyl arms of the wheelchair was cracked and</p>			F0456	<p>1. Wheelchair arms for residents #11, #51, #36, #14, and #1 were assessed and repaired or replaced.2. All resident wheelchair arms were assessed and repaired or replaced as needed.3. The Director of Plant Operations, or his designee will inservice on the use of the "Maintenance Request" form. The form will be used by staff to identify essential equipment repair needs.4. The results of the utilization of the Maintenance Request form will be reviewed at QA monthly for six months and then at least quarterly.5. 3/23/11</p>		03/23/2011

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SS=E	<p>torn.</p> <p>2. At 12:40 p.m., on 2/15/11 at Resident # 11 was in the dining room in his wheelchair. The vinyl wheelchair arms were cracked and torn.</p> <p>3. On 2/15/11 at 3:50 p.m., Resident # 1 was in her room. The vinyl wheelchair arms were cracked and torn.</p> <p>4. During a medication pass observation on 2/15/11 at 11:50 a.m., Resident # 51's wheelchair was in her room. The vinyl arms of the wheelchair was cracked and torn.</p> <p>On 2/16/11 at 9:25 a.m., Resident #51 was observed up in her wheelchair (w/c). Both w/c arms were observed with at least 1/2 of the arms cracked and uneven. At this same time during an interview, CNAs #19 indicated the resident's skin was so fragile, and she was afraid the w/c arms could cause a skin tear.</p>				<p>1. Wheelchair arms for residents #11, #51, #36, #14, and #1 were assessed and repaired or replaced.2. All resident wheelchair arms were assessed and repaired or replaced as needed.3. The Director of Plant Operations, or his designee will inservice on the use of the "Maintenance Request" form. The form will be used by staff to identify essential equipment repair needs.4. The results of the utilization of the Maintenance Request form will be reviewed at QA monthly for six months and then at least quarterly.5. 3/23/11</p>		03/23/2011

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	5. On 2/15/11 at 4:10 p.m., Resident #36's wheelchair was observed. The upper half of the right arm covering of the wheelchair was observed cracked throughout. The left arm's seams were observed partially gapping open.  3.1-19(bb)						